Allied Psychological Services

(Cary)

COUPLES SERVICE AGREEMENT

SCOPE OF CONFIDENTIALITY: I understand that our disclosures to our therapist _____ will not be revealed to outside parties except in the following instances: 1) Where written permission has been provided by **both** my partner and myself. 2) Where my physical safety or the physical safety of another person is threatened; 3) Where evidence is given of physical or sexual child abuse; 4) Where records are subpoenaed by a judge. I also understand and agree that for the purpose of ensuring highest quality of care, my case will be discussed in conference among the employed and contracted staff of Allied Psychological Services. If I should default in paying the balance of our account with our therapist, then I understand that identifying information and dates of service might be disclosed if litigation were initiated.

NO CONFIDENTIALITY BETWEEN PARTNERS: I understand and agree that our therapist shall not be held responsible for keeping any of my disclosures to him as confidential from my partner. Whatever I disclose to our therapist may be disclosed to my partner at our therapist's discretion. This includes information I may disclose during individual sessions, joint sessions, between sessions, and in any type of communication media. If I rescind this agreement, I understand that our services with our therapist will be immediately terminated.

EMERGENCIES: Our therapist uses an extensive paging and messaging system. However, even with a good communication system, I understand that there may be circumstances under which our therapist may not be able to rapidly respond to my needs. If such a situation arises and it involves serious urgency, I agree to telephone Holly Hill Respond for help at **919 250 7000.** I agree to keep this number handy for possible future use.

AUTHORIZATION FOR RELEASE OF PSYCHOLOGICAL AND TREATMENT INFORMATION: I agree that our therapist shall not release any of our information from our couples therapy record unless **both** of us jointly authorize the specific release of information. This means that neither of us will be able to retrieve information from our record unless the other partner also agrees and authorizes it.

RESPONSIBILITY FOR PAYMENT: My partner and I agree that each of us is responsible for paying for each session at the time that services are rendered. We agree that the default of either partner to pay shall not relieve the other partner of the obligation to pay our therapist any debt on the account in full. I also agree to allow our therapist to use any credit card information that I provide for paying off unpaid balances on our bill. I also agree to pay a charge of $ 25.00 for each occurrence of insufficient funds for attempted check or credit card payments on my account. It is my responsibility to inform our therapist of my current address until our final balance is paid off.

MISSED APPOINTMENTS, LATE CANCELLATIONS, AND OTHER CHARGES: Because I will be reserving appointment times in advance at Our therapist, I also agree to pay the usual fee amount for any scheduled appointments that I either miss or cancel with less than 24 hours prior notice. I understand that with less than 24 hours notice to cancel an appointment, our therapist would be likely to lose revenue through unfilled appointment times. In order for me to pay for missed appointments or late cancellations, our therapist is authorized to charge my credit card at the time that such appointments are missed.

It is the policy of Allied Psychological Services to obtain some form of credit to conveniently pay for sessions, missed appointments, late cancellations, and insufficient funds for checks. We require a credit card authorization on file for your convenience as well as ours. That way routine session payments can be automatically processed without having to use up precious time at the end of each session for a manual transaction.

The following credit card information is required:

Full Name on Card (print): _____ Card #: _____

CVV Code: _____ Billing Zip Code: _____

Expiration Date (must be valid for 9 months): _____/_____/_____ Circle: VISA or Mastercard

By signing below, I am indicating that I agree to the above. I also attest that with this service contract, I have been given a copy of "Notice of Policies and Practices to Protect the Privacy of Your Health Information" as is required by law.

Agreed: _____
FIRST PARTNER'S PRINTED NAME

_____ _____
FIRST PARTNER'S SIGNATURE DATE

_____
SECOND PARTNER'S PRINTED NAME

_____ _____
SECOND PARTNER'S SIGNATURE DATE