when using insurance coverage. Likewise, most insurance companies do not cover marriage or family counseling. RECORDING OF SESSIONS. For supervisory issues and client/counselor protection, Wellspring has the right to record client sessions. These recordings are kept confidential and secure, and in most cases, we destroy these recordings within a month. CONTACTING US. We are often not immediately available by phone. Our business line is answered by confidential voice mail that we monitor frequently. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are unable to reach us and feel that you can’t wait for us to return your call, contact your family physician or the nearest emergency room and ask for the psychologist on call. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary. ☐ I, the undersigned, acknowledge that I have received and read this counseling agreement & understand the above information, and agree to voluntarily receive and participate in the counseling process on that basis. I fully understand the responsibility of this agreement. ☐ I, the undersigned, authorize the audio recording of sessions. ☐ I, the undersigned, hereby will be paying for services at the close of each session. ☐ I, the undersigned, understand that if a payment plan has not been established and when charges have not been paid within 30 days of the due date, I agree that I will subject to a late charge of 1.5% per month on the unpaid balance. I agree to pay for any charges for each returned check. The charge for a returned check is $25. ☐ I, the undersigned, understand that all CANCELLATIONS MUST BE MADE 24 HOURS IN ADVANCE OTHERWISE A FULL CHARGE WILL BE MADE. I will be fully responsible for such charges. ☐ I, the undersigned, will be applying for the reduced rate for Wellspring’s Counseling services and the rate we will be paying per session is $\_\_\_\_\_\_\_\_\_\_\_\_. (Please attach Application to this document) ☐ I, the undersigned, understand and agree that if Wellspring Counseling accrue costs in sends my past due amount to, but not limited to collections, Law firm, and/or small claims court, are my obligation to reimburse to Wellspring Counseling, therapist, and/or other affiliates. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client, Parent or Guardian’s Name (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date / /

Client, Parent or Guardian’s Signature

Date / /

Client, Parent or Guardian’s Signature

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Date / /