Jamelyn Keatts, MA LMHC (Lic#: LH60498732)
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408.836.2896

Service Agreement

Jamelyn Keatts, MA LMHC provides professional therapy for individuals and couples. Please read this Service Agreement carefully so you will understand my policies and procedures.

Fees
My fee for appointments is $_____/53 minute session. By signing this agreement, you agree to pay for all services at this rate for all non-insurance covered services provided to you. I reserve the right to change my fees.

Payments
Payment is due at the time of service. However, there may be circumstance including insurance billings that may modify that timing. Please discuss any questions you have about this with me, and a reasonable payment schedule will be determined. We will also discuss and determine the method of payment. If a check is returned because of insufficient funds, you will be charged the actual cost for handling.

Appointments
You and I will set your appointment time. Once established, your appointment is reserved just for you. A missed or cancelled appointment will be charged at the full-session fee. If you are more than 15 minutes late and have not notified me that you are still coming, I may not still be in my office and it will be considered a missed session. Cancellations must be made atleast 48hours in advance or the session will be billed at the full-session fee. **Please note: insurance does not pay for missed appointments.** You will be charged for any additional services you request of me outside of your appointment time. Any time spent testifying in court will be charged at $110/hr including travel time.

Grievance
If you have any concerns or complaints about your therapy, address the issue directly with me.

Insurance
Your insurance may cover a part of the cost of therapy. If you wish to use your insurance, I will bill your insurance company directly. If I am not in-network with your insurance company, you will be responsible for any difference between what I charge and what your insurance company pays for the service. Please complete the Insurance Information below if you wish to use insurance.

Insurance Provider:_____

Policy Number: _____

Group Number: _____

Policy Holder Address: _____

_____

Confidentiality
No information about you is released by me to anyone without your written permission, except as required by law. I am required by law to report suspected child abuse (regardless of when it occurred), elder abuse, and clear and concrete evidence of planned acts of violence. See my Notice of Privacy Practices and Washington Required Disclosure Form for additional details.

Written Records
I maintain written files about your service for five (5) years. You have the right to review your file. If so desired, please arrange such a review with me.

I/We, the undersigned, certify that I have read and understand my rights and responsibilities as outlined in this document. I understand that if I leave therapy with an unpaid balance, I will make every effort to collect these debts. Any attorney fees or costs resulting from my collection efforts will be an additional charge to my balance owing. I understand my obligations under this agreement, and fully agree to pay for my service at my established rate. I do hereby request and consent to treatment by Jamelyn Keatts, MA LMHC. I will participate in the development of a treatment plan that best addresses my needs or situation. I understand that nothing in this Service Agreement shall be interpreted to limit or modify my rights and obligations under the State required Disclosure Form or my Notice of Privacy Practices.

Child Consent
I/We the undersigned parents (or legal guardians) of _____, do hereby request and consent to the treatment of our child by Jamelyn Keatts. We understand we will participate in the development of a treatment plan that best addresses his/her needs or situation.

Client's Signature_____Date_____

Therapist's Signature_____Date_____