

Dr. Brenda S. Butterfield, EdD, MSW, LHMC

The ONE Center: Our New Experience, LLC

Service Contract & Good Faith Estimate

Current Calendar Year _____

1. Scope

I, Dr. Brenda S. Butterfield, have been employed by you, and agree to provide psychotherapy and/or counseling services to you. During our 55-minute session, you can expect to have my full attention, and I will do my best to help you with your situation, issues, or life challenges. I will use a variety of methods to do this which we may discuss at any time.

2. Fee

My current fees are \$225 for intake & evaluation sessions #1 and #2 and \$190 for following treatment sessions. All sessions last approximately 50 - 55 minutes, unless scheduled otherwise for clinical reasons. My per session treatment fee will not be more than \$190 per 55-minute session. I generally see clients weekly until progress toward treatment goals has been achieved and your suffering has been reduced. Services are then decreased typically every other week, monthly, then quarterly. This is ultimately determined in consultation with you the client. The length of treatment is unknown but will also ultimately be determined by you. We can and will discuss this throughout the course of your treatment.

I offer a sliding fee scale to a limited number of clients who need financial assistance. I charge \$150/hour to complete additional paperwork required by employers and/or requested by you which is not part of my routine paperwork process. I charge \$150 for phone conversations with collateral contacts (professionals providing care to you, family members, friends, etc.) needed to provide quality care to you throughout the course of treatment. These fees will not change for you for at least one year. By signing this contract, you agree to the fee of \$225 each for *Intake and Assessment Sessions* #1 and #2, \$190 for follow up *Therapy Sessions*, \$190/hour for *paperwork* you/your employer request I complete and \$150/hour for *phone conversations* on your behalf, or the negotiated sliding fee scale payments of _____. An estimate of your insurance deductible is _____ and your estimated copay is currently \$_____/session after the annual deductible has been met by you. If you are using insurance, you agree to pay the co-pay or uninsured portion at the time of service unless negotiated otherwise with Dr. Butterfield. If you are not using insurance, you agree to pay for these services at the time of service unless you work out an alternative payment plan with Dr. Butterfield at the beginning of your treatment experience. You agree that you will be responsible for any amount not covered by insurance. You will be responsible to assist with any requirements of the insurance company. If for any reason your balance is not paid within 30 days of service, you agree to pay a minimum finance charge of \$3.00 per month or 1.5% per month, whichever is greater.

3. Cancellation, no shows, or short sessions

All sessions last approximately 52 - 55 minutes, unless scheduled otherwise for clinical reasons. Please know I see a limited number of clients/weekly and have set aside time to provide you specifically with the best care possible. Please arrive at your scheduled day/time for the duration of your session. It is not possible to “fill your therapy spot” with another client at the last minute since I do not keep a waitlist or have a receptionist. Insurance companies will not pay for missed appointments or late cancellations. In addition, insurance payments for short sessions are significantly lower. By signing this service contract, you agree to be available for any scheduled sessions or to reschedule your session before Friday if your appointment is on Monday and/or more than twenty-four business hours in advance. If for any reason, you cancel your session late,

do not show up for your session or miss part of your session with less than 24 hours' notice, you agree to pay a fee of \$125 for the missed scheduled session or pay the missed portion of you scheduled session.

4. Confidentiality

I follow the confidentiality ethics of the American Counseling Association as well as State and Federal confidentiality laws. Specifically, this means that your confidentiality is secure with me. In cases of child abuse or intent of physical harm to self or others, I am bound by law to report or seek additional help. See note below regarding HIPAA compliance.

5. Termination

Termination is an important part of the therapeutic process. I request that we acknowledge the end of therapy as it approaches and allow at least one session to complete our work together.

Client Name _____ Date of Birth _____

Client Signature

Date

Provider Information:

Dr. Brenda S. Butterfield, NPI# 1225429699, EIN #47-4352428 LMHC

Services will be provided at The ONE Center

Our New Experience (O.N.E.), LLC is committed to protecting your health information. We are required by law to maintain the privacy of your protected health information or PHI; give you a notice of our legal duties and privacy practices with respect to your PHI; and follow the terms of the Notice currently in effect. This Notice of Privacy Practices is required by the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we use and disclose information about you, called protected health information, to conduct treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information, which may identify you and that relates to your past, present or future physical or mental health or condition, or the provision or payment of your health care. This Notice of Privacy Practices applies to all PHI used to make decisions about your care that we generate or maintain. Different privacy practices may apply to your PHI that is created by other people or entities or kept by other people or entities.