ADONAI CHRISTIAN COUNSELING SERVICES, PLLC.

CAROL D. BUNCH, Ph.D.

8522 Six Forks Road #104, Raleigh, NC 27615

919-801-3199 Phone

adonaiccs@gmail.com.com

CONTRACT FOR SERVICES

CONFIDENTIALITY

Confidentiality will be maintained with the following exceptions:

1. I determine that you are in danger to yourself of someone else.
2. I believe a child or older person had been or will be abused.
3. You sign a release granting me permission.
4. I am ordered by a court to disclose information.

Otherwise, no one will be informed about your treatment, diagnosis, history or that you are a client.

FEES/METHODS OF PAYMENTS

There will be a fee of $150.00 for the initial evaluation session and $100.00 per follow-up session unless other arrangements have been made. Missed appointment is $100.00 Payment is due at the end of each session unless other arrangements have been made. Cash or personal checks are acceptable forms of payments.

BILLING/INSURANCE REIMBURSEMENT

If you wish to seek reimbursement from your health insurance, this agency will be happy to complete any forms related to your reimbursement provided by you or the insurance company. Insurance co-payments are expected to be paid at the time of service and we will file insurance claims for the remaining payment.

Some health insurance companies will reimburse clients for psychological services and some will not. Those that do reimburse usually require that a standard amount be paid by you before reimbursement is allowed, and then usually only a percentage of the fee is reimbursable. You should contact a company representative to determine whether your insurance company will reimburse you and what schedule of reimbursement will be used. However, please remember that you are responsible and not your insurance company for paying the fees agreed upon.

APPOINTMENTS/NO SHOWS

Failure to cancel your appointment within 24 hours can result in a $25.00 no show fee.

If you have any questions, feel free to ask. Please sign and date copies of this form. A copy for your records will be return to you. I will retain a copy in my confidential records.

I agree with and adhere to the above terms of this contract.

_____	_____
Client Signature	**Therapist**
_____	_____
Date	**Date**