Roger A Ballou LLC
Concord, NH

Consent, Disclaimers, Fees, Waivers, and Other Conditions for Service

_____; I/we, the undersigned, understand that these sessions are for individual, couple, and/or family therapy. If more in-depth treatment, including possible use of medications, is needed in the opinion of Dr. Ballou, I/we understand that he will make appropriate referrals for me/us according to professional standards of practice.

_____; I/we understand that Dr. Ballou will keep a confidential file (the medical record) about my/our appointments and proceedings. He has explained that I/we can examine this file upon request with a minimum of 24 hours' notice.

_____; I/we understand that release of the medical record requires my/our signature on a statement of consent. In addition, we understand from Dr. Ballou that exceptions to confidentiality are:

1. Indicators that a child is being abused or neglected.

2. Indicators that an elder or vulnerable adult is being abused or neglected.

3. Indicators that a family member or I present a risk for causing harm to self or others.

4. Health Information Portability and Accountability Act (HIPAA) regulation compliance.

5. Orders of the court (Dr. Ballou always contacts the client immediately prior to turning over any records).

6. My/our approved communication for third party financial coverage (i.e., my HSA, my insurance company).

Should Dr. Ballou find or suspect that conditions 1, 2, and/or 3 are present, I/we expect that he will break confidentiality to protect me/us and/or others.

_____; I/we understand that there is a right to privacy in the individual, couple, and/or family therapy process. Dr. Ballou is not in a position to monitor me/us on a daily basis. Consequently, responsibilities that I/we agree to fulfill when receiving services are:

- To independently schedule and attend appointments with sufficient frequency to meet my/our needs.

- To voluntarily notify Dr. Ballou about any dangers and risks, and discuss the circumstances.

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In the event of a physical or psychiatric emergency, I/we understand that we should either (a) call 911 or (b) go to the nearest hospital emergency room.

_____; I/we understand Dr. Ballou 's fee for service:

- $120.00 per 1-hour session

Cancellations or changes must be arranged 24 hours in advance. I/we fully understand that I/we will pay a $65.00 late-cancellation fee if I/we miss an appointment without providing 24 hours' notice and the appointment time cannot be filled.

_____; I/we understand that, should Dr. Ballou be requested to render any type of service on my/our behalf "between sessions" and/or "out of session", I/we agree to pay Dr. Ballou at the rate of $50.00 per 15-minute increment ($50.00 minimum). This includes consultations, phone calls, letter and memorandum writing, attendance at and/or testimony for hearings, etc. Mileage will also be billed at the federal rate.

_____; I/we acknowledge that Dr. Ballou has made known to me/us that a copy of the New Hampshire Client Bill of Rights (NH Administrative Rule Mhp 502.02) is available on his website.

_____; I/we acknowledge that Dr. Ballou has made known to me/us that a copy of his HIPAA policy is available on his website.

_____; I/we understand that there is no guarantee that I/we will benefit from receiving individual, couple, and/or family therapy.

I/we am/are seeking services from Dr. Ballou under my/our own free will and understand the content explained in this agreement. Dr. Ballou has reviewed each item with me/us. I/we understand and accept the conditions outlined above and acknowledge that I/we am/are free to discontinue services at any time by providing appropriate notice.

_____

Signature Date

_____

Signature Date

_____

Roger A. Ballou, PhD, LMFT Date