ELLEN A. SHERMAN, Ph.D., LMFT

PROFESSIONAL SERVICES CONTRACT

In order to ensure that our relationship is based on mutual understanding and to clarify the nature of a therapeutic relationship, please read this contract carefully. Please initial each category after reading it to indicate your understanding of the terms of our relationship. This is not a legal document.

____1. A typical session is **45-50 minutes**, although longer sessions can be scheduled by mutual agreement and agreed-upon fee.

____2. Dr. Sherman's fee is **$180.00 for individual sessions and $200.00 for couples.** Payment in full is due at the time services are rendered. The fee may be paid by credit card (MasterCard or Visa), check or cash. A receipt for the service can be provided if you wish to submit to your insurance carrier for reimbursement, although reimbursement is not guaranteed. Your fee applies to but is not limited to these services: the therapy session, telephone calls, conferring with other professionals regarding your treatment. Reports are charged separately.

____3. In the event you pay by credit card, please be aware that this service is merely a courtesy and accommodation to you. For these reasons, please understand that using your card represents, warrants and promises you will not stop payment or otherwise advise the credit card company to stop payment or dishonor the charges for services and you expressly waive any right to stop payment or otherwise cancel credit card charges for services rendered.

____4. Please give **24 hours notice of cancellation of appointments** or you will be responsible for half of your full fee. Of course, you will not be charged if you miss an appointment in the event of an emergency.

____5. A $20.00 fee in addition to your usual charge will be credited to your account if your check does not clear. Accounts remaining unpaid for more than 30 days will accrue in interest charges of 1.5% monthly.

____6. Professional reports and/or psychological evaluations carry a charge for the time required to review the records, do research, and compose the reports based on Dr. Sherman's **hourly fee** of $180.00. A statement will accompany the report showing the charges and work done. Payment is due at the time the client receives/takes possession of the report.

____7. In the event that the services of an attorney or collection agency are used to collect any unpaid balance their fee will be charge to you. There is also a separate schedule in the event that I am required to be involved in **litigation** because of services provided you or litigation that requires my attention regarding you as my client. These fees will include a retainer fee, a forensic fee, and out-of-the-office time charges. These fees will be agreed upon and paid **before** the forensic services are provided.

____8. Messages received by voice-mail will be return regularly throughout the business day. Messages received after 5 p.m. will be returned the following business day. **If your message is not returned in a timely manner and you require assistance, please call your primary care physician, 911 or go to your local hospital emergency room for assistance.**

____9. I live and work in this community and it is possible we will encounter each other in public. I will not acknowledge or speak to you unless spoken to. Please do not be offended; this behavior is to protect your confidentiality.

____10. If you should decide to terminate therapy and we have not discussed this termination, I will close your file after 30 days of no contact. Please understand that this is done to protect both of us from any liability, especially as I would no longer be the treating therapist.

11. E Mails, texting and any other forms of social communications are not confidential documents. Please be careful to limit your communications to making and changing appointments in case others see them. Please limit your calls and texts to the office number: 561-361-0670.

____12. Please authorize Dr. Sherman to charge your credit card after each session. This will expedite payment and provide convenience to your therapy experience. This information will be strictly confidential.

Type of credit card_____
Name on card_____
Card Number_____
Expiration Date_____
Pin _____

I have read and understand the terms of this agreement.

_____ _____

Client Signature Date

_____

Ellen A. Sherman, Ph.D.
Florida LMFT1430/LMHC 2622