The Medical Hypnosis & Counseling Center, P.C. | Sandi Y. Squicquero, M.Ed., LPC

1180 Main Street, Suite 5B | Windsor, CO 80550 | Phone (970)-674-0191 | Fax (970)-674-0221 | www.medhypnosis1.com

Office Procedures and Client Contract

1. The purpose of counseling is to assist you in achieving mental, emotional, social, physical, social, moral or spiritual equilibrium based on various methods and strategies. The first session is to evaluate and identify your needs. As sessions progress, the counselor will review her assessment with you, discuss expectations and suggest a plan of treatment.
2. This office is HIPPA compliant and follows strict guidelines with handling protected health information. By signing below, you are acknowledging you have read through the Notice of Privacy Practices for Sandi Y. Squicquero, M.Ed., LPC. Please feel free to request a copy of our Privacy Practices.
    a. DUTY TO REPORT- If there is a probability of imminent physical injury or abuse to yourself or others, or suspected child abuse, without an investigation, medical and/or law enforcement will be contacted.
    b. It is my policy to report any suspected or known animal abuse, to the proper authorities, who may then investigate.
3. The initial consultation is $120 and subsequent sessions are $95 for a 50-minute session or $50 for a 25-minute session. Rates may increase in the future upon a 30-day notice. The same fees apply for all teletherapy sessions. Sessions for hypnosis may vary, most packages are available at a bundled rate, which must be paid for in the entirety at the first session. Payment in full is expected when the services are rendered, unless prior arrangements are made.
    a. A credit card is required to be on file with our office before you present for your first session, see credit card authorization form or ask or office for more details.
    b. Twenty-four (24) hour notice for appointment changes or cancellations is required otherwise you will be charged the usual session fee. If emergencies arise that prevent 24-hour notice, these will be resolved on an individual basis.
    c. If you are more than 15 minutes late to your regular session you will be billed the full session fee and your session will be rescheduled.
    d. You are liable for the full amount of charges, including any amounts billed to insurance that insurance does not pay.
    e. Smoking cessation, as well as other bundled hypnotic analysis success programs are a series of 5 sessions. The full payment of $500 is due for the entire 5 sessions at the first session and is non-refundable.
    f. Professional letters will be charged a fee, starting at $95 and is due at the time the letter is received by the client.
4. I hold the right to deny services to anyone who I believe I am unable to provide proper treatment for. In case of an after-hours emergency, please call 911 or go to your nearest hospital emergency room.
5. Please understand that your health is your responsibility, as well as informing me of any changes that affect our treatment plan. Please be honest and disclose truthful information to get the most out of our sessions. Understand that the results of psychotherapy or hypnotherapy are not guaranteed.
6. In addition to psychotherapy, hypnotherapy or teletherapy may be offered as treatment options to you. Your signature on this document serves as your written consent for these services. If you have any questions regarding these options, please discuss them at your session.
7. You shall indemnify and hold harmless Medical Hypnosis and Counseling Center, P.C. from any claims, lawsuits, demands, causes of action, liability, loss, damage and or injury of any kind, whether brought on by an individual or other entity.
8. Your information is protected, limited confidential information may be shared with your insurance company, other medical professionals, business associates hired by me and my medical billing service, Northeast Ohio Medical Systems (NEOMD), who can be reached at 1-800-778-1242.

I have read and understand the procedures stated above and agree to abide by them. By signing this agreement, I am acknowledging that I have the actual legal power by agreement (parenting plan, etc.), right and authority to make this agreement. I have received a copy of this agreement for my records.

Responsible party signature _____ Date _____

Client name _____ Date _____

Counselor Signature _____ Date _____