



Summit Families First, LLC

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AGREEMENT FOR THERAPEUTIC SERVICES

I understand and agree to services through Summit Families First, LLC. While these services may be Court ordered, I understand that there are rules through this organization that I am obligated to follow for ongoing participation in this program.

Although some organizations may be able to bill therapeutic visits to insurance, Summit Families First does not bill any sessions to insurance. Payment is due forty-eight (48) hours before service. We accept all debit/credit cards and often processing fees will be incurred. Checks are not accepted. A 48-hour notice is required for all cancellations. Your hourly assigned fee will be charged for the missed appointment. Your appointment time is reserved specifically for you. Policies regarding charging for missed appointments appear in the Financial Policy.

Therapeutic Supervised Visitation Provider

There is a difference in rate between a student intern, a provisionally licensed provider, and a fully licensed provider. You may request a specific licensure level but there is no guarantee of availability. Additionally, over the course of visits if you start with a provider working towards independent licensure there is a chance they will progress in this process during the course of visits. If this happens *the fee will reflect the change in licensure status.*

Student Interns

A student intern is a graduate level student enrolled in an internship class and working towards their clinical hours for graduation. They receive at least one hour of supervision with a clinical supervisor at the site of their internship and additional supervision by their academic supervisor through their educational institution. Due to this level of supervision interns are often authorized to work within a similar scope to a fully licensed provider. Cases are assigned based on the supervisor's confidence in the intern's ability to meet the needs of the case.

Authorization to Treat

I understand that my child(ren) will be identified as the patient in treatment and visitation will be based on the parent-child relationship being beneficial to the child(ren). The emotional and physical welfare of the child/ren is the principal concern. I give consent to my therapist to provide assessment and therapeutic services to my child(ren), within the scope of their license.

I also understand that although there will be goals for therapeutic services there is no guaranteed outcome.

I understand and agree to the above terms of service.

Name

Date