Joyful Hearts Counseling

Leslie Pechkurow, LPC, RYT, RPT-S

Welcome! Thank you for choosing Joyful Hearts Counseling. My name is Leslie Pechkurow, and Joyful Hearts Counseling is my private practice. I am pleased to offer counseling services to children, adolescents, and adults who are hoping to live with less stress and more peace in their lives. Whether you are healing from a past trauma, looking to improve relationships, or would simply like to live a more fulfilling life, I would be honored to accompany you through this journey.

A little about my experience…I am a Licensed Professional Counselor (LPC-14134), independently licensed in the state of Arizona to practice psychotherapy. I have been working in the behavioral health field since 2004, and I have worked in a variety of setting with a variety of populations. The type of therapy I use is a mixture of the experiences I have found most helpful in working with clients. When working with children I utilize a lot of play therapy techniques because this is the language that children can relate to. I am also trained as a Registered Yoga Teacher (RYT), and so I bring in mindfulness, meditation, and breathwork into my sessions with children, adolescents, and adults alike. Most important, I look to you as the expert in your life as my guide to what will make therapy a positive experience.

I believe that we all come to a point in our lives when we could benefit from the support and encouragement to help us overcome obstacles. Sometimes you will be on the helping end, and sometimes you will be on the receiving end. My passion is to help those who are ready to make changes and are open to someone walking with them to live a more joyful life.

Thank you,
Leslie

Joyful Hearts Counseling

Client Information/Assessment Form

Client (child's) Name: _____Birth Date: ____ /____ /_____
(Last) (First) (M.I.)

Client Address:_____

City-State-Zip:_____

Telephone: (home)_____(cell)_____ May we leave a message? □Yes □No

E-mail address:_____ May we use to communicate? □Yes □No

Parent/guardian:

_____ Custody: □ Joint □ Full □ None
(Last) (First)

Address (if different):_____

City-State-Zip:_____

Telephone: (home)_____(cell)_____ May we leave a message? □Yes □No

E-mail address:_____ May we use to communicate? □Yes □No

Parent/guardian:

_____ Custody: □ Joint □ Full □ None
(Last) (First)

Address (if different):_____

City-State-Zip:_____

Telephone: (home)_____(cell)_____ May we leave a message? □Yes □No

E-mail address:_____ May we use to communicate? □Yes □No

Best method of contact for appointment reminders? □text □e-mail □phone call □other_____

Client's School:

_____ Telephone:
_____

Place of Employment (client): Telephone:

_____ _____

Place of Employment (parent/guardian (minor client) Telephone:

_____ _____

Place of Employment (parent/guardian (minor client) Telephone:

_____ _____

In Case of Emergency: Contact person: Telephone:

_____ _____

Joyful Hearts Counseling

Treatment History

Has your child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes, previous therapist/practitioner:

_____

When and how long?

_____

Has your child ever been hospitalized for a psychiatric condition? □ No □ Yes
If yes, describe date(s) and circumstances:

_____

_____

Is your child currently taking any prescription medication? □ No □ Yes Please list with does:

_____

_____

If yes, who is your child's prescriber:_____

Has your child ever been prescribed psychiatric medication? □ No □ Yes
Please list and provide dates, along with the prescriber names:

_____

_____

General Health

1. How would you rate your child's current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems your child is currently experiencing:

_____

_____

2. How would you rate your child's current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems your child is currently experiencing:

_____

_____

3. What types of physical activity does client participate in and how often?

_____

_____

4. Please list any difficulties your child experiences with appetite or eating patterns:

_____

_____

5. Please list any concerns with your child's developmental history or educational needs:

_____

_____

6. What kinds of hobbies or extracurricular activities does your child participate in?

_____

_____

Presenting Concerns

What would you like to see improve for your child during your time in therapy?-

_____

_____

Do you see any potential barriers to your child's participation in therapy?

_____

_____

Who do you consider to be your family's support system?

_____

_____

What do you consider to be some of your child's strengths?

_____

_____

Any other important information about your child to consider?

_____

_____

Joyful Hearts Counseling

Client Rights and Responsibilities

The following is to inform you of your rights as a consumer of counseling services and to outline your responsibilities as a client. Please read the following carefully so that you may be as informed as possible in giving consent to treatment. Please initial next to each statement.

Treatment Engagement

_____
Initial

Parents/guardians and children have the right and the obligation to participate in treatment decisions and in the development and review and of your treatment plan. You also have the right to refuse any recommended treatment or to withdraw consent to treat and to be advised of the consequences of such refusal or withdrawal. Children and their families are often given homework assignments between sessions in order to facilitate growth and progress. You have the right to refuse these assignments at any time with the understanding that this could prolong your time in therapy. As your therapist I will remain dedicated to your treatment and will provide quality care to the best of my abilities. I ask that the child (client) and family also take responsibility for the progress in counseling by remaining engaged and committed to the treatment goals. I also request that at least one parent/guardian remain on the premises of the office building throughout the duration of the appointment. Our collaboration together will yield the best results!

Treatment Frequency

_____
Initial

As a client you have the right to schedule and attend counseling sessions at your own convenience. As your therapist I will recommend a frequency that will promote the best possible progress towards your counseling goals. You may choose to schedule/attend sessions that are not as frequent with the understanding that progress may be compromised and total time in therapy may be prolonged. After 60 days of inactivity between sessions (meaning over 60 days between sessions) Joyful Hearts Counseling reserves the right to place your file on "closed status." This means that you are no longer a client of Joyful Hearts. If you would like to seek therapy after this time period you can simply contact Joyful Hearts Counseling and set up a therapy appointment to begin your therapy journey once again.

Purpose, limitations, and risks of treatment

_____
Initial

Counseling is a process in which an individual seeks professional help to find relief from a stressful situation, event, or issue. While the ultimate purpose of counseling is to reduce your distress through a process of personal change, there are no guarantees that the treatment provided will be effective or useful. Moreover, the process of counseling usually involves working through tough personal issues that can result in some emotional or psychological pain for the client. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, relationships, or virtually any other aspect of your life. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. While my goal, as the therapist, is to accompany you through this process and to facilitate a meaningful experience, I cannot guarantee that psychotherapy will yield positive or intended results at all times.

Our Relationship

_____
Initial

The client/counselor relationship is unique in that it is exclusively therapeutic. In other words, it is inappropriate for a client and a counselor to spend time together socially, to bestow gifts to one another, to attend family or religious functions, or to "friend" or "follow" one another via social media. The purpose of these boundaries is to

ensure that you and I are clear in our roles for your treatment and I can remain an unbiased participant in your treatment. If there is ever a time when you believe that you have been treated unfairly or disrespectfully, please talk with me about it. It is never my intention to cause this to happen to my clients, but sometimes misunderstandings can inadvertently result in hurt feelings. I want to address any issues that might get in the way of the therapy as soon as possible.

Payment policy

_____
Initial

Payment is due at the beginning of each counseling session. You may pay with credit card, cash, check or through Paypal. An extra 3.5% + $0.15 charge will be added to a credit card transaction for processing fees, and an extra 2.9% + $0.30 will be added for Paypal fees. The payment scale is as follows:

Initial intake session	$145
50 minute Individual/Family session	$130
Late cancellation/no show	$130

Because the scheduled session time is set aside specifically for you and cannot be used by others, a minimum of 24 hours is required for rescheduling or cancellation of an appointment to avoid payment.

Clients who use insurance to pay directly for counseling sessions should come to the first appointment with their insurance card and knowledge of what the payment responsibility is. Clients who are not prepared with this information may have to use part of the session to call and verify the insurance plan or will need to pay the full amount of the session until copay responsibility can be confirmed. The responsibility lies on the client to verify whether or not he/she is covered and how much he/she will need to pay at each visit. Please note that if any excessive re-billing is needed due to lack of information regarding insurance or changes in insurance coverage an extra charge of up to $25 may be added to your bill.

Telephone calls/communication between sessions

_____
Initial

Brief telephone calls regarding a schedule change or asking for a specific piece of information are encouraged. Please allow 24 hours for non-emergency phone calls, e-mails, or texts to be returned. Established clients with an urgent need may call, but an immediate response is not guaranteed. If the concern is regarding something significant, you may want to schedule an appointment. More extensive phone conversations (over 15 minutes in duration) may be charged accordingly as a regular office visit (as well as extensive e-mails and texts).
I do not have the capability to respond immediately to a counseling emergency, and so if you experience a crisis in between counseling sessions, please call 911 or one of the crisis lines:

Empact Suicide Prevention Center/24 Hour Crisis Hotline – 480-784-1500
Teen Lifeline 1-800-631-1314
Maricopa 24 Hour Crisis Hotline 602-222-9444
Across Arizona 1-800-252-6465

Requests for Written Documentation and Review of Chart

_____
Initial

Requests for any type of written documentation will be considered and addressed as it pertains to the overall treatment goals of therapy. Requests may include but not limited to a summary of client's progress, a summary of therapy notes, and/or other paperwork that may pertain to client's well-being. Joyful Hearts Counseling reserves the right to fulfill or deny any request based on the appropriateness to therapeutic process. Requests that require more than 20 minutes to complete will be charged at $40 per half hour.

Joyful Hearts Counseling

Termination Policy and Procedure

_____
Initial

Clients may terminate treatment at any time. Joyful Hearts Counseling may also terminate treatment for the following reasons:

a. The therapist determines that she does not have the expertise to treat the client's problems.

b. The therapist determines that the client needs a higher level of care and she doesn't provide the scope of services needed for the client.

c. The purpose of therapy becomes one that focuses on a custody decision or placement of a minor child. Joyful Hearts does not provide therapy for the purpose of determining custody or providing testimony in court. If this is the intent of the guardian we ask that you please seek another provider.

d. The client is failing to adhere to the treatment plan – i.e. failure to notify the provider of significant changes in condition, not following through with recommendations for treatment to the detriment of client's progress.

e. Excessive cancellations/changes to appointments or after three cancellations within 48 hours/no shows during the course of treatment.

f. Failure to pay outstanding charges on client account or failure to pay for services to include no show fees.

g. Inappropriate behavior (e.g., threats, violence, damage to property, or illegal behavior).

If Joyful Hearts terminates care, the client and family will be provided written notice including the reasons for the termination and referrals for alternative sources of treatment (if, in the opinion of the provider, the client would benefit from some further treatment).

Privacy Notice

_____
Initial

I acknowledge that I have reviewed a copy of the HIPPA Privacy Notice of Joyful Hearts Counseling ad understand its content. If requested a copy will be provided to me.

Consent for treatment of a minor

_____
Initial

If parents/guardians have joint custody of a minor in counseling, then both parties must sign the consent form. Legal documentation denoting any custody arrangements must be provided before counseling services can begin.

I have read the above information, and I voluntarily consent to have my child participate in counseling services with Joyful Hearts Counseling. My signature on this document indicates that I exercised my option to ask questions about any aspect of the treatment and that my questions were answered to my satisfaction. I understand that I have the right to revoke this authorization. Until then this document remains in full effect.

_____	_____	_____
Client signature	Date	Name printed
_____	_____	_____
Parent/guardian signature	Date	Parent/guardian name printed
_____	_____	_____
Parent/guardian signature	Date	Parent/guardian name printed

Joyful Hearts Counseling

Confidentiality Policy

Joyful Hearts Counseling regards confidentiality with the utmost importance, therefore it is essential that clients understand the limits and boundaries of confidentiality. In general, all information disclosed within a psychotherapy session, whether written or spoken, is confidential and legally privileged. Your therapist is the only individual who has access to your file, unless you direct your therapist, in writing, to disclose information to specific entities. However, there are a few circumstances under which a therapist is legally and ethically bound to disclose information:

Duty to Warn and Protect

1. When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities.

2. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

3. Abuse of children and vulnerable adults: If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

4. Prenatal Exposure to Controlled Substances. Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Other circumstances that allow for disclosure include the following:

Legal Proceedings:

A court may require disclosure of confidential information in a legal proceeding in which your condition or treatment is a relevant concern. This may include, but is not limited to, legal proceedings such as a child custody hearing, board complaint, or criminal action.

Professional Consultation:

As an independently licensed therapist I am not required to receive clinical supervision, however, in an effort to provide services that reflect best practices I belong to a group of therapists that meets regularly to discuss client care. When a client is discussed identifying information is kept confidential to the extent necessary.

Confidentiality in Group/Family Counseling

Members of a counseling group are not bound to the same ethical and legal mandates that therapists are, however, if you do participate in a group or family counseling all members are asked to respect and maintain the confidentiality of what is disclosed during the course of treatment.

Minors in treatment (under the age of 18)

Parents/guardians of minors in treatment have the legal right to information that is shared during the counseling process, however parents/guardians are encouraged to respect their child's right to privacy and confidentiality. Parents/guardians can be assured that their child will be encouraged to share critical information and feelings with them, and the therapist will ensure parents/guardians are informed if a minor is in danger of serious threat or harm.

Secrets Policy

Secrets, when held from a family or significant other, can be destructive to the relationships of the individuals involved, including the holder of the secrets. When working with families the therapist reserves the right, when asked to maintain a secret, to work towards its disclosure as the therapist and individual together determine the appropriate time.

Treatment Records

The therapist is required to maintain treatment notes, which include but are not limited to: dates of treatment, diagnosis, treatment interventions, and goals. The client (or parent/guardian in case of a minor) has a right to request records, however if examination of any part of these records would have an adverse effect on the client (or parent/guardian), the therapist is permitted to withhold that information and will provide justification for doing so.

Use of electronic and phone communication

Although Joyful Hearts Counseling utilizes firewall and password protection for computer use, e-mail is not an encrypted form of professional exchange, therefore confidentiality cannot be guaranteed in this form of communication. When a client chooses to communicate using e-mail the client assumes the risk that the exchange may be intercepted. Joyful Hearts also employs the use of a password to protect any voicemail or text messages (again not encrypted). If a client chooses to text the therapist and/or gives permission for the therapist to leave voicemails, the client again assumes responsibility that these messages could be viewed by another party. Please note that all communication completed through technology is also a part of the official record of the client.

_____(initial) **I give permission to Joyful Hearts Counseling to leave a voicemail/text on this number _____.**

_____(initial) **I give permission to Joyful Hearts Counseling to correspond through e-mail using this e-mail address_____.**

I understand that only necessary information will be conveyed in any message left for me/my child.

Insurance Claims

In the event that an insurance company requests information other than on the claim form, this office will provide only a summary, with your written permission. Copies of progress notes from your confidential file will not be released. Most insurance companies require a diagnosis in order to pay for services.

Joyful Hearts Counseling

As you can see the laws and rules on confidentiality are complicated. However, you should now have enough information to enter treatment well informed about the confidentiality policy. Please let your therapist know if you have any questions or would like further information.

I have read the information on the Confidentiality Policy of Joyful Hearts Counseling, and my signature indicates that I understand and comply with this policy.

_____	_____	_____
Client signature	Date	Name printed
_____	_____	_____
Parent/guardian signature	Date	Parent/guardian name printed
_____	_____	_____
Parent/guardian signature	Date	Parent/guardian name printed

Joyful Hearts Counseling

Therapy Collateral Agreement

Client_____ DOB:_____

I/We_____(parent/guardian/other)

_____(parent/guardian/other)

have been invited by_____(client's name) to attend one or more therapy sessions with Leslie Pechkurow, LPC (hereinafter "the provider"). I understand that the purpose of my attendance is to provide support to the client during phases of treatment, or to assist in the process in some other way. I understand that I do not have a personal relationship with the provider and that she is not providing psychological services for me. Rather, I will function as a therapeutic ally, assisting with the client's therapy. I understand that my participation is entirely voluntary, and I am free to withdraw at any time, or decline to answer any questions or to participate in any exercise. I understand that what I say to the provider may become part of the medical record and may be discussed later between the provider and the client when I am not present. I understand the client remains at all times that holder of the privilege, with the sole authority to release his/her records and may do so freely without my consultation or participation, even if I am mentioned or referred to in those records. I agree that if I am experiencing any emotional or mental difficulties, and am not currently receiving adequate treatment for these problems, I will make this fact known to the provider, who will suggest resources or referrals for assistance. The provider has explained all of the above to me in detail. My signature reflects that I have had an opportunity to ask questions regarding this agreement and am satisfied with the responses. My signature also reflects my agreement with the conditions of TCA and that I participate freely.

Signature (parent/guardian/other) Date relationship to client

Signature (parent/guardian/other) Date relationship to client

Joyful Hearts Counseling

Agreement

In the Context of Divorce, Parent/Partner Separation or Transfer of Legal Caregivers

I/We understand that my/our child_____DOB:_____ is receiving therapy from Leslie Pechkurow, LPC. It has been made clear to me/us that Ms. Pechkurow is providing treatment that may include my/our child's adjustment to my/our marital divorce or partner/caretaker separation/guardianship or transfer of legal caregivers. I/We understand and endorse that Ms. Pechkurow is providing treatment and is not acting as an evaluator. I/We further understand that Ms. Pechkurow is not conducting a custody or visitation evaluation on behalf of my/our child.

It is Ms. Pechkurow's professional position not to release child records to non-medical professionals, most especially in the context of custodial disputes. She does, however, provide summaries of care when requested. Her position is that it is often not in the best interest on the child or family to release records to another party or parties as they are then subject to "other" interpretations which could be inaccurate and counter productive to the current or future treatment of the child. Confidentiality and privacy are very important to clients of all ages. If a child is told that Miss Leslie is a therapist "who helps with feelings" then releasing records to a third party could certainly jeopardize her relationship with the child client and possibly be in violation of the ethics of her profession.

I/We further agree to not involve Ms. Pechkurow in any court proceedings regarding my/our child's treatment. Such involvement has the potential of interfering with my/our child's trust in the privacy of this therapeutic relationship and any future therapeutic relationship.

If in the context of treating your child, your child's right to privacy is waived and the records are demanded, please do so by a court order. Ms. Pechkurow may still decline the release of the child's records to attorneys based on disclosure not being in your child's best interest (however she may release the records to the judge for review or final disposition). Ms. Pechkurow requires that all parents/partners/caregivers/guardians be in agreement with said release and any subsequent reports would be made available to all parties unless a court order or a judge directed otherwise.

If the parents/partners/caregivers/guardians object/s to the above, then Ms. Pechkurow would advise that she not be utilized as your child's therapist.

I/We the said parent/s /partner/s /legal caregiver/s /guardians of:

Minor Client:_____ agree/s with the above document in its entirety. I/We have been able to ask questions and all questions asked were answered to my/our satisfaction.

Mother/Partner/Caregiver/Guardian_____Date:_____

Father/Partner/Caregiver/Guardian_____Date:_____

Parent/Partner/Caregiver/Guardian_____Date:_____

Joyful Hearts Counseling

Limits and Risks Associated with Telepractice/Email/Text Use in Therapy

Although I use firewall, and my computer and files are password protected, I cannot guarantee absolute confidentiality in the use of telepractice/email/text exchange. I utilize a conference service that is an encrypted video service and HIPPA compliant, however my e-mail, phone calls, and text messages are not encrypted forms of professional exchange. If you choose to communicate with me via technology in any way, I will assume that you have made an informed decision, and I will view it as your agreement to take the risk that the exchange may be intercepted or interrupted.

Specific to telepractice exchange (phone or video), the client will identify him or herself by stating name, birthdate, and current location (address and phone number). The client will verify s/he is alone and in a confidential location as well as naming an emergency contact. If client is not alone s/he will need to complete the necessary forms for additional people to be present during the counseling session.

It is possible that during our telepractice exchange the Internet connection may be disconnected or paused due to circumstances beyond either of our control. If this happens we will wait 2 minutes and try to connect again. If we are unable to reconnect at or near our scheduled time, we will call or e-mail with alternative times to resume or reschedule our exchange.

Should an emergency arise during a telehealth session, it is important for the client to have a strong safety plan in place, as I am not physically able to provide support. If the client becomes unavailable during an emergency, I will then call the ***local*** emergency contact listed below and/or 911 to ensure the safety of the client.

_____ _____

Local emergency contact name **Phone number**

_____(initial) I authorize the therapist to call my emergency contact in case that a crisis or emergency arises

If I choose to communicate via phone call/text for counseling sessions, or communication between appointments, please use the following number/s:

1. _____- _____- _____ home/cell/work/other_____
2. _____- _____- _____ home/cell/work/other_____

_____ (initial) If there is no answer, I authorize that you can leave a message with your name and number

_____(initial) If someone else answers the call, I am authorized to leave a message with my name and number

My signature indicates my understanding of the limitations and confirms my agreement to include this method of communication in my contact with Leslie Pechkurow, LPC. My signature also reflects that I have had an opportunity to ask questions regarding Leslie's use of telepractice and my questions have been answered.

_____ _____ _____

Client name **Client signature (or parent/guardian)** **date**

_____ _____ _____

Client name **Client signature (or parent/guardian)** **date**

Joyful Hearts Counseling

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face
We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being. If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk).

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the coronavirus within the office, and I have posted these efforts on my website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that I am committed to keeping you, me, and all of our families safe from the spread of this virus. If you show up for an appointment and I believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate. If I test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____

Client signature (guardian signature if client is a minor) Date

Joyful Hearts Counseling

CREDIT CARD AUTHORIZATION

Client Name: _____

Parent/Guardian name:_____

Please initial below for each item:

( ) I hereby authorize Joyful Hearts Counseling to bill the below-referenced credit card for routine treatment services for myself and/or my minor child.

( ) I understand that I can rescind this authorization at any time and arrange for alternative fee payment methods (i.e. cash, check, or alternate credit card).

( ) I acknowledge that in the event of missed or late canceled appointments (canceled with fewer than 48 hours' notice), my card will be charged a full session fee ($120.00 per session) for the missed appointment.

( ) I have been made aware that a record of all fees associated with my or my child's treatment can be made available to me within seven (7) business days of my request.

Card Holder Name: _____

Credit Card Number: _____

Expiration date: _____**CVV:**_____

Billing Address: _____

_____

Card Holder Signature: _____ **DATE:** _____

Joyful Hearts Counseling

Good Faith Estimate

You are entitled to receive this Good Faith Estimate of what charges could be for psychotherapy services provided to you. While it is not possible for Ms. Pechkurow to know in advance how many psychotherapy sessions are necessary for any given person, this form provides an estimate of cost services provided. Your total cost will depend on the number of sessions you attend, your unique circumstances, and the type and amount of services provided to you.

This Good Faith Estimate shows the cost of items and services that are reasonably expected for your health care need for an item or service.

This estimate is not a contact and does not obligate you to obtain any services from Joyful Hearts Counseling, nor does it include any services rendered to you that are identified here.

This estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. There may be additional items or services I may recommend as part of your care that must be scheduled or requested separately and are not reflected in this Good Faith Estimate. You could be charged more if complications or special circumstances occur. If this happens federal law allows you to dispute the bill.

You have the right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges). For questions or more information about your right to a Good Faith Estimate or the dispute resolution process, visit: http://www.cms.gov/nosurprised/consumers or call 1-800-985-3059.

Based on a fee of $120 per visit at one psychotherapy session per week your estimated charge would be: (This is a high estimate for 12 months of service)

$6,240 (weekly) **$3,120** (every other week) **$1,440** (monthly)

****If you are using insurance and have a copay and/or deductible you are responsible for communicating with your insurance plan to determine what that payment/session is.**

If you attend psychotherapy for a longer period, your total estimate charges will increase according to the number of sessions and length of treatment.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case and the estimated cost for those services depend on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendation made to you concerning your treatment, and you may discontinue treatment at any time.

_____ _____

Client name Therapist signature

_____ _____

Client signature (guardian signature if client is a minor) Date