

**Valerie D. Wise, LCSW**  
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[www.valeriedwise.com](http://www.valeriedwise.com)

Effective September 1, 2019:

Informed Consent Notice and Fee Payment Agreement

\$125.00/Individual; \$175 Couple or Family Session

\$40.00/Individual/group session

All of our work together, our conversations, your records and any information that you provide is protected by legal privilege. There are some exceptions to your privacy that you need to understand:

- I If there is a perceived danger that you might harm yourself or someone else, I may be required to contact authorities or the other person, to give them the chance to protect you.
- I If you are abusing children or elderly people, or disabled adults, authorities must be notified so they can protect others from harm.
- I If you become involved in any lawsuit in which your mental health is an issue, for example a custody dispute or an injury lawsuit in which you claim compensation for emotional pain and suffering, then the court or the lawyers may insist upon and my obtain information from me.

My goal is to provide you with quality mental health care. Your informed participation and your understanding of payment arrangements are essential to my effort to help you, as well as your effort to benefit from our time together. The following statements describe our agreement regarding the services that I will provide and the fees charged for our time and services:

1. Payment may be made by cash, personal check, money order or via PayPal- PayPal by going to [www.valeriedwise.com](http://www.valeriedwise.com). Credit or debit cards are not accepted for payment of fees.
2. Messages for me may be left 24 hours a day at 708-269-8063. Throughout the day, I check messages regularly and whenever possible I will return phone calls the

same day. If I have not returned your call within 24 hours, please try again as your message may have been lost. If you call during during weekend hours (Friday after 12:00 p.m. to Monday 8:30 a.m.) I will follow up with you on the next business day.

3.      If a scheduled appointment must be cancelled or rescheduled, a 24-48-hour notice is appreciated. **A full session may be charged for failed appointments or cancellations with less than 24-hour notice.**
4.      After hours telephone calls may be accepted. There is no charge for a phone call that lasts 10 minutes or less. For telephone consultations that require more than 10 minutes, the charge will be \$40 for each 15 minute increment or any part of a 15 minute increment. These fees are due and payable when they are incurred, but must be paid by the time of your next scheduled visit. Payment via [www.valeriedwise.com](http://www.valeriedwise.com) is preferred.
5.      There may be times when you request time for the reading of documents that relate to your treatment of your personal or medical history. You may be billed for this time.
6.      Other charges may apply: If you or someone else that you authorize needs a copy of your file or of other records that may be legally necessary, my office charges a reasonable fee for copying, plus postage. If my office is required to provide a verbal report, for example, by telephone to your physician, a 10 minute consultation will not be charged. If the consultation exceeds 20 minutes, the charge will be \$40 for each 15 minute increment or any part of a 15 minute increment. If a written report must be prepared as part of your treatment, the same fee will be billed for the time spent reviewing your file and drafting and publishing the report.
7.      Professional advice will not be provided via the internet; email communication may be used for scheduling appointments with your permission. Allowed email address for appointment/scheduling/rescheduling: [lifedancer1@comcast.net](mailto:lifedancer1@comcast.net).
8.      A \$25.00 NSF bank charge will be applied for any returned checks. After two NSF checks within one year, fees must be paid in cash.
9.      By your signature below you agree that in the event of your counselor's death or disability, the office may designate a proper custodian to be responsible for the disposition of your records.

I have read and understand this agreement. By my signature below, I agree to all of the terms outlined above.

Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_