

# *Service Agreement*

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## *Our Mission*

Thank you for contacting us to serve you. Our mission is to help you make the kind of changes you wish in your life. We offer to help you make the changes you want to the best of our ability and make referrals when necessary with your interests in mind. We are dedicated to inspire and empower individuals, couples, groups and organizations toward their quest for healthier, happier lives through providing professional psychosocial-therapeutic interventions for growth and change.

## *Services offered*

Individual Counseling	\$110	Hypnosis supervision	110
Couples Counseling	110	Hypnosis Group	30
Wellness Programs for organizations	Call	Smoking Cessation	275
		Report Writing	30
Stress Management	Call	Court-Related Services	150
Body-Mind Workshops	Call		
Clinical Supervision	90		

## *CDs*

**Binaural Beats** Stimulates theta brain waves for relaxation 10.00

**Changing Weighs** Lose weight through a stereophonic system of talking with the right and left brain. You don't have to figure it out... just relax effortlessly. 15.00

**Transforming Weighs** Enjoy a metaphorical journey for weight loss. It has added benefits of using binaural beats for enhanced relaxation. Perfect for stress eaters. 10.00

**Capturing Serenity** Relax. Experience an ultimate relaxation in just 20 minutes. 10.00

## *Should I Use Insurance?*

Therapy can be expensive. Knowing the benefits and risks can help you decide how to proceed.

### **The Benefits**

- Co-payments can be low.
- You may not have a copay

### **The Risks**

- You must qualify for a mental disorder diagnosis, which would have to be disclosed to your insurance panel.
  - The diagnosis becomes the focus of your therapy, rather than the reason you contacted your therapist.
- If you need to apply for a life/disability insurance/private health insurance, your company has access to your health information. This can effect eligibility and premiums.
- Insurance panels may have case managers consult with your therapist to get ongoing sessions authorized. They decide whether your therapy is a "medical necessity.
- Some EAPs do not allow reports to be written for disability or 3<sup>rd</sup> party organizations. If you require such services PLEASE make sure this is part of your contract.

## *If you plan to use insurance*

As a courtesy, we will bill your insurance company for your visits. We will contact your insurance company to verify your outpatient therapy benefits. Information received from your insurance company is not a guarantee of payment. Benefits are subject to provisions and eligibility at the time service is rendered.

To avoid an unpleasant surprise about your coverage, please contact your insurance company prior to your first visit for authorization. It is important that to keep a record of whom you talk to and what you are told regarding your benefits. Although we file your insurance and check your benefits, if for any reason your insurance company denies payment for services rendered, you become responsible for the outstanding balance.

## *Payments Accepted*

Pay Pal, Checks, Cash  
Visa Mastercard Discover

Your payment or co-payment is expected at the beginning of each session. Also, please realize that any amounts left unpaid by your insurance (such as annual deductibles) will be your responsibility to pay.

## *Non payment*

After 60 days any unpaid amount is turned over to a collection agency (without prior

discussion of plan for payment)

A 30% charge is added for collection agency fees

A 40% charge is added if the account is over 1 year old) By signing this form you are binding yourself to this contract.

*Late Cancellation and No Show Policy*

Your session is reserved exclusively for you. A failed appointment or cancelled appointment without a 24-hour notice in advance will be charged **\$90**. Your insurance does not pay for this.

*Emergencies*

**Call 911**

Go to your nearest Emergency Room

*My commitment to your privacy*

Your confidentiality is important to us. There are certain legal and ethical limits that can be released without written consent. State and federal law mandate that child abuse, elderly abuse, and one who is a threat to self or others will be reported to the proper authority for your protection. When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization who is able to help prevent or reduce the threat.

By signing this form you authorize us to release the information to obtain reimbursement and agree to the terms of this agreement:

Patient signature \_\_\_\_\_

Date \_\_\_\_\_