

**Counseling Agreement • Kirsten M. Lundeberg, LPC, LMFT**  
**3923 Old Lee Highway, Suite 63 D**  
**Fairfax VA 22030 • Phone: 703.599.1478**

**I. SESSIONS AND FEES**

A standard session is 50 minutes. My current fee for therapy sessions is \$135 per 50-minute hour. The fee for a 90-minute session is \$245. I do not participate with any insurance carriers, and therefore I request that you pay for each session at the time of that session. At the end of every month, I will provide you with a receipt with the information necessary to submit your claims to your insurance provider if you choose to do so. You are responsible for submitting this paperwork to your insurance provider. It is my policy not to let outstanding bills exceed \$270 without payment. Please note that this contract takes precedence over any information provided by your insurance carrier.

There is no charge for brief check-ins by phone. Extended phone consultations or off-site meetings are billed at \$135 per hour. My fee for services related to court, such as preparation, consultation, and report writing is payable at \$150 per hour. My minimum fee for appearing in court is \$2,250 for an eight-hour day, or \$1,250 for an afternoon, payable ten days in advance.

I recommend weekly sessions when we first begin to establish a strong therapeutic relationship. Sometimes clients request (or I may recommend) sessions more often than once per week based on the presentation of symptoms. Together we will discuss any need or recommendation regarding schedule change.

**II. CONFIDENTIALITY**

Services provided are confidential from those outside of the treatment unit unless: 1) someone is in significant danger of hurting him/herself or someone else, 2) if there is a suspicion of child abuse or abuse of an elderly or disabled adult, 3) if there is a court order (subpoena), 4) if I have your written consent giving me permission to speak with individuals outside of the treatment unit, or 5) if you request that I submit information about diagnosis and treatment to your insurance provider. If several members of your family attend sessions with me, or when working with partners in couples therapy, information shared with me by one family member is not necessarily confidential from others in

treatment. If you are a young adult and your parent(s) is/are financially responsible for therapy, I may share a general treatment plan with them and treatment recommendations as appropriate.

### III. CANCELLATION POLICY

Please notify me as far in advance as possible if you need to cancel a session. **If you miss a session or cancel with less than 48 hours notice, you will be charged the full session fee (\$135 for a 50 minute session).**

If you are paying by credit card, signing below authorizes me to charge your card for the amount due at the time of the session, as well as to charge your card for a missed appointment or for an appointment that is not canceled with 48-hours notice.

### IV. TERMINATION

You may, of course, terminate treatment at any time. If you cancel or miss scheduled appointments and do not contact me for more than 30 days, it is understood that you have terminated treatment. Once treatment is terminated, the therapist has no further obligation to the client. If you have completed a course of therapy and wish to resume at some point in the future, I will make every effort to accommodate your scheduling needs.

### V. EMERGENCIES

In the event of a life-threatening emergency, please call 911 or go to your nearest hospital emergency room. You can also call Fairfax County 24-hour emergency services at 703.573.5679.

Your signature below indicates that you understand the above terms. Please ask for clarification of any points.

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Printed Name of Client

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Signature of Client      Date

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Printed Name of Financially Responsible Custodial  
Parent/Guardian if Applicable

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Signature of Financially Responsible Custodial Date  
Parent/Guardian if Applicable