BULL CITY PSYCHOTHERAPY PLLC
Caudle & Associates

Bull City Psychotherapy, PLLC
Professional Counseling Policies and Agreement

www.bullcitypsychotherapy.com

1816 Front Street Suite 250
Durham, NC 27705
(919) 382-0288

Thank you for choosing Bull City Psychotherapy, PLLC for your counseling needs. My role as your counselor will be to provide individual counseling and support to you as you work towards your goals. The purpose of this form is to establish our goals of counseling and the professional expectations and conditions for our working relationship.

As your counselor I will utilize various techniques and theories to best meet your individual needs. I will support you as you work through the issues that have brought you here. As your counselor, I will treat you with respect at all times and meet you where you are developmentally as a client.

From time to time, I may also utilize different assessments throughout the counseling process in order to best determine your needs and support you in the most effective manner possible. We also may use a workbook or journal for reflections. If at any time you have ideas or suggestions for your counseling needs, please do not hesitate to let me know, as you are the expert of yourself☺

The fee for individual counseling is $125 per 50 minutes session, couples counseling per 75 minute sessions are $175, individual Intake assessments are $125, and couples intake assessments are $175.

Cash, check, Master Card, Visa, Discover, American Express, are accepted, and if you choose to pay with a credit card, this will be charged using Square, and by you signing this form, you give permission for us to charge you for your visits. A sliding scale is available on a financial need basis on Bull City Psychotherapy, PLLC's discretion.

Your appointment is an important time that is scheduled just for you. Please call or email me at least 48 hours prior to your appointment if you need to cancel or reschedule. If you do not show up for an appointment or cancel in a time frame that is less than 48 hours, then you will be charged.

I commit to holding all of your information confidential unless in the case of the following scenarios: (1) Duty to warn. Threats or intent to harm self or others; (2) Reasonable suspicion of abuse of a child; and

(3) When ordered by the court. Confidentiality may also be broken in one's defense against a legal action before a court.

Please feel free to call my cell phone whenever you have a question or concern. My cell phone number is 828-989-2278. You may also email me at maggie@bullcitypsychotherapy.com for non crisis or non confidential matters. Please note that text and email communication cannot be guaranteed as confidential. **In case of an emergency, please call 911 or go to your nearest emergency room.**

Thank you very much and I look forward to working with you in our professional counseling sessions. Please read this document and feel free to ask me any questions you may have. At your convenience, please sign below and return to me. I will give you a copy for your records at our first meeting.

By signing this form, you give consent for your private diagnosis and insurance information to be electronically submitted for the purpose of you receiving direct reimbursements from your insurance company, if applicable. Electronic submission of healthcare information is conducted through Therapy Notes Software, which is HIPAA compliant.

By signing this form, you agree to use Zoom, which is a HIPAA compliant secure telemedicine or teletherapy program, if that type of meeting is schedule with you or your provider.

By signing this form, you give consent for consultation to occur, if needed, by the professional staff at Bull City Psychotherapy.

By signing this form, you also agree to be charged if you neglect to return a book on loan from the library of Dr. Sophia Caudle or Bull City Psychotherapy, PLLC.

By signing this form you give consent for paid invoices to be emailed, understanding that paid invoices have diagnosis information and cannot be guaranteed to be emailed securely. You may opt out of receiving emailed paid invoices by initialing here:_____

Counselor (Name printed)_____ Client: (Name printed)_____

Signature:_____ Signature:_____

Date: _____ Date:_____

Credit Card #_____ Guardian name:_____

Ex Date:_____ 3 digit code:_____ Signature:_____

Name on card:_____

Billing zip code:_____