YOUR  
LOGO

**COMPANY NAME**

MENTAL HEALTH SERVICES PROPOSAL

Prepared by:

**[Client Name]**

**[Contact information]**

**[Date]**

# Introduction

Thank you for considering [Your Name/Practice] to support your mental health and wellness journey. We provide compassionate, confidential, and evidence-based care to help clients build resilience and improve overall well-being.  
  
This proposal outlines the approach we will take to support [Client Name] or [Client Group] through therapeutic services.

# Client Goals

[Client Name] seeks support in managing [anxiety, depression, stress, trauma, relationships, etc.] and improving mental and emotional health.

# Proposed Services

We propose a customized mental health support plan including:  
  
- Initial intake and psychological assessment  
- Individual or group therapy sessions  
- Wellness planning and goal setting  
- Regular check-ins and progress reviews

# Scope of Work

Our mental health services include:  
  
- One-on-one counseling (in-person or virtual)  
- Group therapy (if applicable)  
- Psychoeducation and coping strategies  
- Collaboration with healthcare providers (with consent)  
- Confidential records and client support

# Timeline

Estimated timeline for therapeutic engagement:

|  |  |  |
| --- | --- | --- |
| Phase | Description | Estimated Date |
| Initial Intake | Assessment and care planning | [Start Date] |
| Therapy Sessions | Weekly or bi-weekly meetings | [Ongoing] |
| Midpoint Review | Check progress and adjust goals | [Midpoint] |
| Program Evaluation | Discuss outcomes and future steps | [Completion Date] |

# Pricing

Service fees and payment details:

|  |  |  |
| --- | --- | --- |
| Service | Description | Cost |
| Initial Consultation | Comprehensive intake session | [Amount] |
| Individual Therapy | 50-minute session | [Amount] |
| Group Therapy | Per session (if applicable) | [Amount] |
| Package (Optional) | Prepaid multi-session rate | [Amount] |

# About Us

[Your Name] is a licensed [therapist/psychologist/counselor] with [X] years of experience helping clients work through a wide range of mental health concerns.  
  
- Credentials: [LCSW, LPC, LMFT, PhD, etc.]  
- Areas of Expertise: [Trauma, CBT, mindfulness, adolescents, etc.]  
- Philosophy: Client-centered, evidence-based care that respects individual needs

# Testimonials

Testimonial:  
“[Your Name] helped me feel heard and empowered. Therapy became a safe space for growth.” — [Client First Name]

# Terms and Conditions

Payment Terms: Payment due at time of service or per package.  
Cancellation Policy: 24-hour notice required for cancellations.  
Confidentiality: All client records and sessions are protected under HIPAA or relevant privacy regulations.  
Crisis Protocol: Crisis support information will be provided at intake.

# Acceptance

To begin mental health services, please sign below.  
  
Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name: [Client’s Printed Name or Authorized Representative]  
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_