CONSENT TO SERVICE

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OFFICE POLICIES AND PROCEDURES

Please take a moment to read the following carefully. It outlines important information for you, as a client, or the parent/legal guardian of a client. Please feel free to ask me any questions or discuss any concerns that you may have.

Confidentiality

The information disclosed by you to me is confidential and will not be released to any third party without written authorization from Patient, except where required or permitted by law. Exceptions to confidentiality, include, but are limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another.

APPOINTMENTS/CANCELLATION POLICY

Sessions are 50 minutes in length.and family and couple sessions are 75 minutes in length. The scheduling of an appointment involves the reservation of time set aside specifically for you. If you need to reschedule or cancel an appointment, please do so as far in advance as possible and indicate whether you want to reschedule within the appointment week. **You will be billed for the full session fee for all appointments cancelled with less than a 24hrs notice. You will not be charged for a late cancellation if you are able to work out a make-up session within the week of your original appointment. Therefore, if you call and leave a message to cancel a session, please let me know if you desire a make-up session.** Because you have entered into therapy in order to accomplish personal treatment goals, you should be aware that continuity and regularity of our sessions, facilitates a smooth process.

FINANCIAL POLICY

Payment can be made in the form of check or cash at the beginning of each session. Fees for additional services, such as extended telephone conversations with you or the parent of a minor, consultation with others (e.g. physicians, attorney's, etc) court appearances, etc. will be based on the nature and extent of the service in accordance with my hourly session rate. As the situation allows, these will be discussed with you prior to the service.

INSURANCE INFORMATION

If you are utilizing your health insurance, please note that my professional services will be charged to you and not the insurance company. Monthly statements will be generated and emailed to you. If you desire, required insurance information such as

diagnosis, will be included. These can be submitted directly to your insurance provider for out of network benefits or tax-free medical spending accounts. It is up to you to verify that coverage of outpatient psychotherapy with an out of network provider.

AVAILABILITY/EMERGENCIES
If you need to leave a message that is not of an urgent nature, please leave a detailed message and convenient times and phone numbers when we may reach you. **If you have an emergency**, and require a consultation, please indicate this at the beginning of your message, and leave phone numbers where we may reach you. We will return your call as soon as possible. You will be billed at your session rate for these consultations.

GENERAL OFFICE HOURS
General office hours are Monday through Friday, and we check messages until 5 p.m. We will return all calls left during these hours within that day. All messages left after 5 p.m. or Friday 5pm through Sunday midnight will be returned on the following office day.

VACATION POLICY
You will be given appropriate advanced notice with regard to my scheduled vacations. During these vacation times and on some long weekends, a colleague will be available to assist you in case of an emergency.

I have read, understood, and received a copy of the above policies and procedures and agree to abide by them.

_____
Client/Parent/Legal Guardian/Conservator Date

_____
Client/Parent/Legal Guardian/Conservator Date