Practice Policies

[Organization Name]: Therapists working in the clinic enjoy a collegial and educational professional relationship with several therapeutic disciplines within [Organization Name] Center network. In your particular situation, your therapist works as an independently credentialed clinician through the Clinic and its affiliation [organization name]. Services will be billed to your insurance company via that relationship.

Your Therapist: Sessions with therapists are by appointment only. The best way to contact your therapist is by calling their direct phone number or sending an e-mail to the email provided by him or her. Voice mail will be checked throughout the day and at least once in the evenings and on the weekends. Practitioners strive to respond to VM within 48 hours. In the event of an emergency, please contact [local emergency service hospital name] [phone], [local emergency mental health contact] [phone], 911 or 988.

Appointments: Appointments are typically 50-60 minutes long. Missed appointments are not covered by insurance and may be paid out of pocket. There is a [$--] no show fee if there is not 24 hours notice of a cancellation.

Payments & Insurance: Co-payments are due at the time of the appointment. Payments can be given to the therapist. We do not accept checks. If you are unsure about your balance or have any questions regarding billing, please contact Supervising practitioner [name, email, phone]

Confidentiality: Everything that takes place in psychotherapy is confidential and may not be released without your expressed written permission. There are two exceptions to this: if you or your child becomes a danger to self or others; and if you or your child is involved in child abuse. In these situations, we are legally bound to break confidentiality in order to protect all involved. Confidentiality for children and adolescents in situations other than those listed above will be discussed with you during the evaluation phase of treatment.

By signing this document, I understand and agree with the policies described above. I also understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. If my account is more than 90 days in arrears, I authorize that pertinent billing information can be released to a professional service for purposes of collection of the outstanding balances.

Patient Name: _____ I am patients Guardian Patient

Signature: _____ Date: _____