MISSED APPOINTMENT FEE AND LATE CANCELLATION FEE POLICY

Our Practice requires that in the event you have to cancel an appointment, you must notify us one business day (24 hours) in advance; **phone messages left with the answering service over the weekend do not qualify as 24 hours notice for Monday appointments**. There is a fee for appointments canceled with less than 24 hours notice and a fee for appointments, which are missed with no contact in advance at all. Please be aware that in some cases repeat missed appointments can lead to termination of services, and **none of these fees are insurance reimbursable**.

We would like to emphasize that there are no exceptions to the above policy. In other words, the policy applies even if there is a good reason, such as an emergency that requires you to cancel your appointment.

On the other hand, we do have procedures, which may, in some instances, permit you to avoid such charges. Specifically, if you do cancel with less than 24 hours notice, we do try to find someone to take your canceled appointment. If we are successful, we do not charge the late cancellation fee. Finally, if there is a snow emergency and the police announce a driving ban, and you call in advance of your appointment to cancel, we generally waive the late cancellation fee.

I _____, have read the above information that explains the missed appointment fee and late cancellation fee policies. I understand that at least 24 hours cancellation notice is required to avoid a missed appointment fee or late cancellation fee of $70. In the event that I do not give such notice, only the following condition will waive the fee: if the appointment is filled with another client.

By signing this form, I understand that there are no exceptions to the above policy, including even if there is a good reason, such as an emergency situations that requires me to cancel my appointment. By signing this form, I understand that I am responsible for this fee and it is not billable to my insurance. I have discussed these fees with my therapist and fully understand them.

Name (print): _____

Signature:_____ Date: _____

6556 East Quaker
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PAYMENT POLICY- COPAY

Please be aware that your copay is due at the time of visit as required by your insurance company. A $5 (five) billing fee will be added to your account if your co-pay is not made at the time of service. Please note that an additional fee will also be added each month that the balance still remains (this means that if you have a $10 co-pay and the balance still remains after two months the billing fees will equal an additional $10 making the total balance $20).

Name (print):
_____

Signature:_____ Date:
_____

RELEASE OF LIABILITY

We would like to know if you want to be on our courtesy call/message list. Please place your name, and number to call below. The only information disclosed will be the clinician's name, and the date and time of the appointment. Please fill out the following below:

Please check whether you would like to receive a courtesy email prior to your appointment:

____ Yes _____ No Number: ( )

Be aware that by signing this form you are releasing us from any liability associated with leaving information regarding your or your child's appointment.

Name (print):
_____

Signature:_____ Date:_____

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CONSENT FOR EVALUATION AND TREATMENT
AND
ACKNOWLEDGEMENT OF RECEIPT OF:
HIPAA NOTICE OF PRIVACY PRACTICES & CLIENT-THERAPIST SERVICES AGREEMENT

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. This federal law requires that I provide you with a Notice of Privacy Practices.

I am also providing you with a Client-Therapist Services Agreement, which contains important information about my professional services and business policies.

Your signature below indicates:

- Your consent to participate in an evaluation and / or counseling / psychotherapy (or your consent to evaluation and treatment of your child, if signing as parent or guardian)
- Your permission to provide information to your insurer if you are using health insurance to help pay for services
- Your awareness that your right to the maintenance of confidentiality of the material discussed with will be limited or waived in the event of a court order or subpoena, suspected child abuse or neglect, or statements indicating that you (or your child) may harm or endanger yourself or another person
- Your acknowledgement that you have received copies of the HIPAA Notice of Privacy Practices and the Client-Therapist Services Agreement
- Your agreement to review both the HIPAA Notice of Privacy Practices and Client-Therapist Services Agreement before your next appointment and raise questions or concerns you may have about them as soon as possible
-

Client's Name (printed)	Client's Date of Birth
Signature of Client (if over 18 years)	Date
Signature of Parent or Guardian (If applicable)	Date

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Authorization for Release of Protected Health Information

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize_____ to release the following information regarding

_____ _____
Name of Client Date of Birth

Yes	No	
_____	_____	Diagnosis
_____	_____	Summary of initial evaluation
_____	_____	Summary of treatment to date and progress in treatment
_____	_____	Family assessments
_____	_____	Developmental history
_____	_____	Social history (birth order, living situation, adoption, important relationships)
_____	_____	Medical history
_____	_____	Medication history
_____	_____	Academic evaluations, grades, school performance and behavior
_____	_____	Information relevant to special education classification and services
_____	_____	Other (specify) _____

_____

This information should only be released to:

_____

_____

I am requesting that this information be released for the following reasons:

_____ At the request of the individual
_____ As part of a Committee on Special Education process, school evaluation of educational needs, or for evaluation for special education services
_____ As part of a Disability Determination process
_____ As part of a Worker's Compensation process
_____ As part of a court action
_____ To inform a family member or significant other at my request
Other (specify): _____

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This authorization shall remain in effect until: _____ OR
(expiration date)

until _____
(event that relates to the individual or the purpose of the use of disclosure)

You have the right to revoke this authorization, in writing, at any time by sending such written notification to this mailing address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Signature of Client (over 18 years)	Date
Client's Name (printed)	Client's Date of Birth
Signature of Parent or Guardian (If applicable)	Date
Parent / Guardian's Name (printed)	
Witness (if applicable)	Date

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