STATEMENT OF CONFIDENTIALITY LIMITATIONS/

MISSED APPOINTMENT POLICY

**DEAR CLIENT:**

**The following provides information on certain policies and procedures in my practice.**

* *A client’s right to confidentiality is assured at all times*. Rare exceptions by law that are unprotected involve situations in which a client is deemed dangerous or harmful to oneself or others or when a client discloses information about child abuse or abuse of disabled adults. Other exceptions include the provision of basic information to insurance companies and to a collection attorney when necessary. No information will be released under normal circumstances without your written consent.
* ***In order to insure adequate time for your session,* it is requested that payment be made at the start of the session. Appointments last about 50 minutes.**
* ***It is your responsibility to check with your insurance company regarding coverage of mental health services and if you require preauthorization.* Any services thata third party payer, e.g. an insurance company, refuses to reimburse are also your responsibility. Normally you will have a copayment and/or a deductible, and I will bill your insurance company for the balance of the fee.**
* ***You will be charged $35.00 for a session* if you cancel with less than 24 hours’ notice. If you fail to show up for an appointment without calling, you will be charged a full session fee of $75.00. Exceptions may be made for illness, emergencies and inclement weather. Please note that insurance companies do not reimburse for missed appointments.**
* **You will be responsible for any fees associated with *returned checks*.**
* ***All phone calls are answered as promptly as possible,* at the least within one business day. Please always leave your telephone number and when I can best reach you.**
* ***If you are in need of immediate assistance, please call me at 401-415-6002.* Only crisis calls are returned during after-hours. In the event you cannot reach me immediately and you feel that you require assistance, please call 911 or consider going to your nearest emergency room.**

**I have read the above statements and have been given the opportunity to ask questions. I give permission to Laurie Lennon, LICSW to provide diagnostic and treatment services to me.**

**Client’s Signature Date**

# Client’s Name Printed