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PATIENT POLICY NOTICE

My session fees are $300 per therapy hour (45 minutes). A double session is 90 minutes. Payment for services is expected at each visit unless other arrangements are made in advance. Payment may be made by cash or check. Patient is responsible for payment of all charges. There will be a $20 service charge for returned/bounced checks. If your account is referred to a collection agency or court, you are responsible for paying any attorney and collection fees. You will be notified in writing when fees are increased. The charge for my office to create any special reports or letters is $100.00.

If you have insurance, you will be provided with an insurance statement to submit to your insurance company. I am not a contracted provider with insurance companies. Services are not rendered on the basis that your insurance company will reimburse you. If you do not use your insurance claim forms, please file them in case you change your mind. The charge for my office to recreate your insurance forms is $100.00 per twelve month period.

I understand that personal schedules change, however your appointment time has been reserved for you and without proper notice, it becomes difficult to replace the appointment with another patient. If you need to cancel or reschedule an appointment, please let me know before 12 midnight of the day of your appointment. Cancellations without this notice, missed appointments, and late arrivals will be billed at full fee for the time reserved, unless another agreement is made. Patients are responsible for keeping track of their own appointments. If I accidentally double-book your appointment, and am unable to see you and we reschedule, there will be no charge for your rescheduled appointment.

In order to effectively and safely manage your medication, I need to speak with you by telephone every three months, and see you **in person** every six months. It is also your responsibility to get blood work done once a year so I may view the results. I need to know immediately if you experience any side effects from medication prescribed by me, if you are put on another medication by another physician, or if your health status changes.

_____ _____
Patient Name Date

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Signature of Patient