Office Policy

Please Read Carefully

Length of Sessions

Psychotherapy sessions are 50 minutes in length. Please feel free to call when necessary as it may be important to contact me to continue your progress in therapy. Phone calls are free unless they exceed 20 minutes and then you may be charged for a therapy session. Therapy sessions will be held weekly or biweekly. I do not do every other week sessions.

Payment

Unless otherwise arranged, fees are payable at the time of service. If you are paying by check please have it filled out in advance. Credit cards, bank transfers, PayPal, Venmo, Zelle or cash is acceptable.

Insurance

I am not an in-network provider and as such I do not accept co-pay or insurance in lieu of payment. As a service to you I can submit your insurance claims electronically. Whatever insurance pays will be deducted from your next session. Please call your insurance company to find out what your reimbursement is. Please keep track of all payments so you are assured that you are getting the right amount deducted. If at any time your have questions about your insurance, please let me know or contact your insurance carrier. Please call immediately if there is any discrepancy with your compensation and I will work out a full refund.

Rescheduling

Emergencies or extenuating circumstances may arise that may cause you to cancel your regularly scheduled appointment. I will make every effort to provide a free make up as my schedule permits. As it is very complicated to reschedule appointments, I need **24 hours notice.** If at any time I can fill that appointment even if it is not within 24 hours I will not charge you for the missed session.

All communications during the therapeutic hour are private and confidential. You own the information and I cannot legally provide that information to anyone without your expressed written permission. There are certain exceptions. They include child abuse and/or if you are a danger to yourself or others.

I have read and understand the above information pertaining to psychotherapy and confidentiality. If I authorize electronic insurance billing I agree to release information about my name, address, birthdate and social security to my insurance carrier.

Signed____Date____________________

Print Name____