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PSYCHOLOGICAL/THERAPEUTIC RESOURCES, LLC

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SOME INITIAL INFORMATION FOR OUR PATIENTS

Regulations now require us to have you read and sign multi-page forms in order to receive treatment. However, we don't want you to spend the majority of your first session with us doing paperwork. For these reasons we have provided this brief information form. You can review any questions you may have about its content (or the contents of the more comprehensive Outpatient Services Contract) with your clinician. It is important that you do this because we will not be able to serve you unless all forms are completed. What follows is some basic information to acquaint you with some of our policies.

CONFIDENTIALITY: Respect for your privacy is extremely important to us. For this reason, no information will be released about you without your permission. However, if you intend to hurt yourself or someone else or you say something that raises even the possibility of abuse, by law we are obligated to break confidentiality.

APPOINTMENTS: Appointments are made by office staff and the scheduled time is reserved just for you, so it is important for you to be on time if you wish to make full use of your appointment. We normally **do not** provide appointment reminders. Twenty-four hours' advance notice of cancellation is required**.** If you miss your scheduled therapy appointment, and you have not notified us at least 24 hours in advance you will be required to pay the full cost of the session unless otherwise arranged with our practice. Clinicians reserve the right to terminate therapeutic relationships after multiple cancellations or failures to appear for appointments.

PAYMENTS: We will obtain insurance information at the first visit and will file insurance as a courtesy to you; *however, each patient is ultimately responsible for charges incurred in the event insurance does not pay.* It is rare for an insurance plan to pay 100% of charges for outpatient health services. Therefore, the patient is expected to pay his or her deductible (if not already paid for the year) and the co-payment (the percentage of charges the insurance company will not pay) **at each visit**. There will be a $20.00 charge for returned checks and/or a late payment penalty on balances 60 days past due.

I have read the above policies. My signature below indicates that I understand my obligations in treatment and I agree to meet them. I also agree to read and sign the **Outpatient Services Contract** before my next appointment.

___ I have been informed of my rights to review/receive HIPAA Health Information.

___I have received a copy of the Outpatient Services Contract

Date _____ Signed _____

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