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Welcome to my practice. I have prepared some information for your review before we begin working together.

My psychotherapy sessions are usually scheduled on the hour and finish at 15 minutes before the next hour. Usually, I meet with patients once per week or every other week, but there are circumstances when a different schedule is more appropriate. I am glad to discuss your scheduling preferences with you.

Once an appointment is scheduled, you are responsible to keep the appointment unless you cancel it with at least 24 hours advance notice. I charge my full fee (currently $180) for missed appointments and for cancellations with less than 24 hours notice. Please understand that insurance cannot be billed for missed appointments or late cancellations. You would be responsible for the full amount.

I can be reached, if needed, between appointments at (856) 465-5027. You will likely reach my voicemail, but I am conscientious about returning calls. I generally return all of my calls by the end of the day. Under unusual circumstances, I might be delayed in returning a call until the following day. If you have not heard back from me by then, please leave a second message. If you are having an emergency that cannot wait for me to return your call, please make use of a local hospital emergency room or crisis center.

The information you share with me is confidential under most circumstances. Your signature below provides consent for me to disclose basic information about you for billing health insurance or other third party payers; collecting overdue fees through a collection agency, small claims court, or attorney; and consulting other professionals regarding your care. Your signature below also provides consent for me to release information about you to a colleague who covers for me while I am away from the office for vacation or other reasons. You are also consenting for a trusted colleague to have access to information about you in order to contact you in the unlikely event that I become unable to continue your treatment due to disability or death. In the unlikely event of receipt of a court order, defense of a lawsuit or ethics complaint, belief that a child or vulnerable adult has been abused, and any imminent risk of suicide or of serious physical violence, information about you may be released even without this consent. Of course, there may be other situations when you want me to release information about you. You would need to sign a form specifically authorizing such a release of information. Please understand that your records contain personal information about you; I will gladly review your records with you upon your request. A more comprehensive list of the exceptions to confidentiality and of your rights regarding your records is presented in the HIPAA Privacy Notice presented with this form.

My charge for the initial session, which is a diagnostic interview, is $230. After the initial session, my fee is $180 per session. Payment is due at the time of service. I participate with several insurance plans that may pay a part of the fee for sessions. These plans include

Aetna Behavioral Health, Value Options, some Blue Cross / Blue Shield plans, and Medicare. I also have an arrangement with the Division of Vocational Rehabilitation to provide services to their clients. If I participate with your insurance plan, I will submit bills to your insurance company and accept assignment. If I do not participate with your insurance plan, you will be required to pay the full fee at the time of service, and I will provide you with a receipt that includes the information usually required for you to submit an out of network claim to your insurance company. Please understand that I am conscientious in following contractual provisions and laws requiring me to collect copays, coinsurance, and deductibles.

Sometimes a patient's responsibility is unclear or an incorrect amount is collected at the time of service because the details of the insurance coverage are not known. Any such discrepancy will be rectified when an EOB or other insurance statement clarifies the correct amount. Although I expect that you and I would cooperate in dealing with any problems regarding payment that your insurance company presents, ultimately it is your responsibility to resolve such problems, to be aware of your coverage and the limits of your coverage, and to know your copay or coinsurance for each session. Your signature below acknowledges your responsibility for full payment of my fees if for some reason your insurance company does not pay or if you do not have insurance coverage.

I consider my relationship with my patients a collaborative one, in which we work together toward your goals. I generally am open about my diagnostic impression and treatment recommendations, so that we can embark on a course of treatment that makes sense to you and is likely to benefit you. Of course, diagnostic impressions and recommendations may be clarified or revised as our work together progresses, and I cannot guarantee success. Please understand that psychotherapy can have risks, including but not limited to the discomfort of experiencing difficult emotions and of modifying behaviors and relationships. I invite your ongoing feedback, and I hope that you will feel comfortable expressing concerns of any kind about treatment.

Thank you for considering this information.

YOUR SIGNATURE BELOW INDICATES YOUR CONSENT FOR TREATMENT, INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS, AND SERVES AS AN ACKNOWLEGMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

(In the case of a minor, a parent or guardian's signature indicates consent for the minor's treatment, acceptance of these terms, and acknowledgment of receipt of the HIPAA notice.)

Signature:____Date__________