The following statements represent the policies and procedures of this office. Please read the following information and sign below.

Office Hours: Mon. thru Fri. 9 am to 6:00pm

Basic Service Rates: ***Sessions are 55 minutes. I prefer to be paid by check. Please have your check ready before the session. I prefer handling financial transactions and scheduling at the beginning of the session.***

Initial Evaluation:	$150.00
Family/Couples Therapy:	$135.00
Intervention Therapy/Training	$135.00
Individual Psychotherapy:	$125.00
Group Psychotherapy:	$50.00

Evaluations and Reports: Evaluations, reports and letters will be written at the request of client. Fees for theses services will be discussed at the time of the request. Fees for evaluations, reports and letters must be paid for in advance by the client.

Appointment Policy: Kindly give 24-hour advance notice to cancel or reschedule your appointment. ***If you do not cancel or reschedule your appointment within 24-hours of the appointment, you will be charged the full fee for that appointment.*** You will have to pay that fee prior to your next appointment. Insurance does not pay for this charge. Appointments start at the scheduled time and last for 55 minutes. If I am late, I will make arrangements with you to compensate your time. If you are late, the session will be ended at the normal time.

Payment for Services: ***Payment is due at the start of the session.*** Checks are accepted. Credit cards and debit cards are not accepted. An NSF charge of $50 will be assessed for all returned checks. A second NSF check will require establishment of an alternate payment method. I will file claims with your insurance company if I am "***in network***." ***I will not file claims for "out of network" benefits.*** You will be given a fee ticket that you can file with your insurance company.

Phone Calls: I will return phone calls in a timely manner. For emergent situations, utilize crisis intervention services (i.e. The Phone @ 924-3900), 911, or the emergency department of your local hospital.

Confidentiality: Information about you will not be released without your written consent or subpoena from a Judge. As mandated by law and for your safety, confidentiality will be pre-empted in high risk situations of child/elder abuse/neglect and in cases of homicidal or suicidal threats and behavior.

Client:_____ Relation to Client:_____

Witness:_____ Date:_____