# POLICIES AND PROCEDURES

## APPOINTMENTS

**The keeping of appointments is the most effective means of successful therapy. As schedule permits, we will work with you to find a convenient time for your appointments. Scheduling of appointments constitutes an agreement to pay for the professional time reserved for you. Our policy is to charge appointments missed or cancelled with less than 24 hours of notice at the rate of the reserved session. You will be billed directly for this time. We also charge for telephone and/or communication consultations with your provider, which are longer than five minutes, at the usual and customary rate should the doctor deem it appropriate.**

## PAYMENT OF FEES

**Payment for services is to be made at the time of the appointment. We accept cash, check and MasterCard or Visa. Unpaid account balances must be paid in full by the close of month. Unpaid balances older that 90 days will be charged an interest rate of 1.5% per month.**

**Should it become necessary to seek outside help to collect on an account the patient will be responsible for any additional fees or charges and an interest rate of 15%.**

**The patient is responsible for the provider's fee plus expenses should a court appearance become necessary. There will be a $25.00 charge for all returned checks.**

**Appointments may be rescheduled until payment is received.**

## CONSENT TO RELEASE INFORMATION

**Patient agrees that his or her provider may share information with others providers in the practice to better provide quality care. This information will be confidential.**

## REPORTS, CONSULTATIONS AND OTHER CLERICAL DUTIES

**Any reports, professional consultations or tasks involving time beyond that of the regular scheduled session will be pro-rated and charged according to the professional or clerical time involved.**

**PLEASE READ CAREFULLY AND SIGN BELOW: I have read and understand the above statements. I agree to comply fully with the policies of this office. I recognize and accept full financial responsibility for all services rendered.**

**Patient/Resp. Party Signature _____**

**Date_____Witness_____**