Insight Therapeutic Services Patient Information Form

Welcome to Insight Therapeutic Services. Please read the following information regarding my policies. Please ask if you have any questions or concerns.

Sessions, Fees, Payments:

Session Length: Typically, 45-60 minutes long, but some sessions may be longer or shorter.

Fees for Most Services:

Initial Diagnostic Evaluation/Intake:	$110
Additional psychotherapy sessions:	
Psychotherapy 60 min (53 min+)	$135
Family or Couples counseling session:	$110

Additional services (including, but not limited to, letter writing, disability or legal preparation, documentation, work documentation, phone calls 10 minutes longer, etc.) will be billed accordingly. Please note these services are not generally covered by insurance.

Fees are subject to change. If fees are changed, you will be provided with a revised Patient Information Form if you have an appointment occurring within the month before the fee change, or at your next appointment after the fee change, whichever is applicable.

Payments:

Co-pays and other fees are due on the day of your visit and will be collected before the session. Payments can be made at our office, by mail, and by phone to the main office, 205-936-2356.. If you are unsure as to what your insurance will cover, please call your insurance company or our business office. If an alternate person is the responsible party for payment (i.e. parent of a college student, legal guardian, noncustodial parent, etc.), payments must be made by the responsible party before the session. It is your responsibility to inform our office of any insurance changes.

Overdue Accounts:

You (or your responsible party) are responsible for payment of any unpaid balances. It is important to me that financial concerns do not interfere with progress of therapy or prevent you from obtaining needed services. If you need to arrange for a payment plan, please call Victoria Frazier LICSW with our main office, 205-936-2356. If your account is overdue, and if you have not made a "good faith" effort to satisfy your account, then the account may be turned over collections, and services may be suspended. If there are financial issues or questions, please feel free to speak with me.

Cancellation and No Show Policy:

Cancellations:

Please call to cancel 24 hours before your scheduled appointment.

At times, I may need to cancel and will try to give you as much notice as possible. If due to illness or emergency, you might be notified of the cancellation on the same day. Of course, I

do my best to reschedule your appointment within a reasonable time frame so as not to interfere with your progress.

No-Shows/Late Cancellations:
No shows can interfere with the progress of therapy. Please be aware that when you schedule an appointment, that time is reserved for you exclusively. If you are unable to come to your appointment, please let us know as soon as possible so that we can make your appointment time available to another patient. I certainly understand illnesses and emergencies, but please call (or have someone call for you) your therapist directly. If you do not reach them, please leave a voicemail or text message for them.

> ***Late Cancellations***: **If you cancel without a 24-hour notice for reasons other than illness or emergency, you may be charged $50.**
>
> ***No-Shows*: If you fail to show for an appointment without calling first, you may be charged $75.**
>
> These fees are not covered by insurance and will be your responsibility to pay before your next appointment. These can be paid via card on file system.

Credit Card on File Authorization:
Please complete this section for Insight Therapeutic Services to keep your credit card on file for future payments. This card will be charged if an appointment is canceled not within 24 hours of notice per the signed informed consent agreement and if you do not show for your scheduled session. Please note that in the event that your insurance provider does not reimburse Insight Therapeutic Services for your sessions, we will attempt to communicate with you to resolve prior to applying balance to card on file. If you need to set up a payment plan or have questions regarding your insurance coverage, please contact Victoria Frazier at 205-936-2356.

Cardholder Name: _____

Card Number:

Card Type: Visa MasterCard American Express Discover

Expiration Date:

Security Code: (3 digit code on back)_____

Billing Zip Code: _____

I, _____ authorize Insight Therapeutic Services, LLC to charge the above credit card account for payments owed to my account for services rendered at their office. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

<u>Confidentiality</u>:
Your confidentiality is of utmost importance to me. What you tell me is confidential, meaning that I cannot reveal what you tell me to anyone unless you give me a specific permission by signing a Release of Information Form specifying the recipient information. There are some exceptions, however, when I can tell someone what you tell me without your permission:

1. If there is reasonable cause to suggest that you are an imminent serious danger to yourself (suicidal intent, plan, etc.), I may need to inform someone else (i.e., family member, partner, doctor, etc.) in order to protect you. If there is reasonable cause that you intend to/threaten to inflict serious physical harm/death to a specified victim, I may need to take protective actions which may include informing the potential victim(s) and/or law enforcement about the threat. In such cases, hospitalization may be initiated to protect you and/or others.
2. If there is reasonable cause to suspect, or evidence of, a child or vulnerable adult being abused or neglected, I am required to report the information to appropriate state governmental authorities [e.g., Department of Human Resources (DHR), etc.].
3. If there is a court order for your records and/or to speak with me.

If such a situation arises, I will make every effort to fully discuss it with you before taking action, and I will limit my disclosure to what is necessary.

I have read and understand, and agree to Insight Therapeutic Services' policies. I understand that I am free to bring up any questions or concerns I have at any time.

_____ _____

Signature of patient (all patients, ages 14- adult) **Date**

_____ _____

Signature of parent/guardian, if applicable **Date**