

OFFICE POLICIES

Confidentiality

Generally information revealed by you is kept strictly confidential and will not be revealed to any other person or agency without your written permission. However, in the following exceptions, I am required by law to reveal information about you without your permission:

1. If you threaten grave bodily harm or death to another person, I am required by law to inform the intended victim and the police.
2. If a court of law issues a legitimate subpoena, I am required to provide information specifically mentioned in the subpoena.
3. If you are in therapy ordered by a court, the results of treatment must be revealed to that court.
4. I am required to report child abuse or neglect.

Length and modality of therapy

Ordinarily the therapy hour is 45 to 55 minutes in length. Initial therapy visit might be up to 90 minutes. Most people do therapy once weekly. Please let me know if you need to be seen more frequently. Therapy can be done in individual, couple, family, or group format.

Phone calls

I try to return all of my calls within 24 hours. I will also do my best to see you as soon as I can if you need it. However, if I am unavailable (during weekends, holidays) please call Arapahoe Douglas Mental Health and ask to speak to a crisis worker (Ph. 303-730-3303). In case of a life threatening emergency, please call 911 or go to the nearest ER.

Informed consent There are great benefits of psychotherapy to you and your significant others. Most therapy sessions will be moderate in nature and bring noticeable relief. However, at times intense negative emotions such as fear, sadness, etc. can be aroused during a therapy session—emotions connected to remembering unpleasant events or processing them. Important conditions of therapeutic success are honesty and openness in exploring one's life, and wiliness to face a range of emotions and variety of opinions without becoming defensive.

Insurance billing

It is important for you to verify your insurance benefits for outpatient mental health services prior to your sessions. I can bill your insurance company as a courtesy to you. Insurance companies occasionally require current progress information as a condition of payment.

I, _____, hereby authorize my therapist to release information that is requested by my insurance carrier for the partial payment of my bill. I also authorize my therapist to collect payment from the insurance carrier for professional services rendered. **I agree to pay my portion of the bill in full.**

Payment/co-payment is due at the time of service. Delinquent accounts are placed with an agency for collection (in this case 40% collection agency fee and other fees will be added to the amount due).

Cancellations and missed appointments

Please give me **at least 24-hour notice (preferably more)** if you need to reschedule. This gives me a chance to schedule an appointment with the person who needs to come and can make it. In cases of no notice or short notice, when the hour is basically lost, the full contractual cost of the session is your responsibility (please note that most insurances and EAPs do not reimburse for no shows or short notice cancellations). Two missed or rescheduled appointments in a row can mean that continuation of therapy at that time is in question.

Please put your appointments on your schedule (your planner, phone) as I don't have a receptionist to remind you of them.

I acknowledge that I have read these policies.

Client or Responsible party

Date