4865-A Cordell Ave #250
Bethesda, MD 20814
PH 301.821.1723
www.bethesdaplaytherapyhealing.com

POLICIES FOR CLIENTS

Please read the information below and feel free to ask any questions. You have the right to ask or as much information as you would like in order to make an intelligent decision about the services you desire.

1. **APPOINTMENTS:** Standard appointment time is 50-55 minutes for a psychotherapy session. If you are late for the session, that time will be lost from the session. Your therapist will make every effort to be available at the scheduled time.
2. **FAILED APPOINTMENTS:** The time that has been reserved for you is your time. Appointments not cancelled 24 hours in advance will be subject to a cancellation fee. You, not your insurance company, will be billed a fee of $75.
3. **BILLING:** Clients are responsible for obtaining accurate information from insurance carriers as to deductibles, copayments, and precertification. Any errors in information received, resulting in a balance owed to provider, will be the responsibility of the client to pay. Clients are also responsible for becoming aware of any changes in their coverage and notifying their therapist. Copayments are due when services are rendered. Clients are ultimately responsible for fee payment, regardless of coverage. Your signature below authorizes your insurance company to pay Bethesda Play Therapy and Healing, LLC directly for their share of the fees.
4. **TELEPHONE:** Telephone contacts between sessions should be limited to critical issues or appointment scheduling. If at all possible, telephone contacts should be limited to normal business hours (Monday – Friday, 8:30a.m. – 5:00p.m.). **Extended phone contact/consulting will result in a billed session with rate of $35 per 15 minutes.**
5. **MISCELLANEIOUS FEES: Returned checks** will result in a service charge of $25. A fee will be assessed at the usual hourly rate ($150) for letters, reports, forms, etc. requested by client. The party responsible for my participation in any court proceedings agrees to reimburse me at $150 per hour.

Please check each statement and then sign below. I, undersigned,

__________ agree to the policies described above
__________ have reviewed the Statement of Limits of Confidentiality
__________ have read and agree with the patients Rights and Responsibilities.
__________ have read/received a copy of this Office's Notice of Privacy Practices.
__________ give consent for evaluation, psychotherapy, and /or psychological testing

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Please Print Name (Responsible Party) Client Name

____

Signature Date

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

FOR OFFICE USE ONLY

______Individual refused to sign
______Communication barriers prohibited obtaining the acknowledgment
______An emergency situation prevented us from obtaining acknowledgment
______Other (Please Specify)

Revised 6/24/19