

OFFICE POLICIES AND PROCEDURES

Confidentiality

All information disclosed within sessions or consultations is held strictly confidential and may not be revealed to anyone without a written release of information, except where disclosure is permitted or required by law. Disclosure is required in the following circumstances:

1. When there is a reasonable suspicion of child abuse or neglect, or abuse to a dependent or elder adult,
2. when the patient presents an imminent danger to self,
3. When the patient presents an imminent danger to others,
4. If a judge determines that our discussions are not confidential, a judge may request specific information.

If the patient is a minor, you acknowledge that your child's records are confidential except in the above stated exceptions. Please be aware that submitting mental health claims to your insurance company carries a certain amount of risk to confidentiality, privacy, and to future capacity to obtain health or life insurance, or even a job. I receive regular professional consultation by choice. In such cases, neither your name, nor any identifying information about you is revealed.

Phone & Emergency Contact

If you need to contact me by phone, do not hesitate to call my office number. If I am not available, you can leave a message on my voicemail and I will usually return the call that day. In the event of an emergency, please follow the prompts so that you can be forwarded to an operator that can page me. You will be charged for phone calls if we have a conversation of an information-exchanging or problem-solving nature that lasts more than 10 minutes. If you cannot reach me in an emergency, you can find help at the following suicide prevention/crisis numbers: (800) 715-4225 or go to the nearest emergency room.

Therapy Process & Termination

Psychotherapy can result in a number of benefits to you, including improved relationships and a reduction in psychological symptoms. The process of talking about painful memories, thoughts, and feelings, however, can be difficult and can make patients feel worse for a time. Please discuss this with me if you are feeling worse. There is no guarantee that therapy will yield positive or intended results. I do expect patients to complete homework or other assignments and be actively working on issues. Most problems require at least 8-12 sessions. Many times it takes much longer than this, up to a few years. You are free to terminate therapy at any time. I can provide you with referrals to other therapists at your request. **I do not perform custody evaluations and do not make recommendations regarding custody nor do I consider myself a criminal behavior expert.** I also do not prescribe medication but I do make note of ALL medications you are taking. I can also refer you to our physician and/or psychiatrist if I believe you are in need of a medication evaluation.

Behavioral Innovations, LLC
551 N Cherokee Rd P.O. Box 689
Social Circle, GA 3006

Patricia Dunsha, LPC
Patricia@myonestopdoc.com
Ph: 770-825-8124 Fax: 770-825-9066

Cancellation of Appointment

The scheduling of an appointment involves the reservation of time specifically for you. In the event of a "No Show" or failure to give a **full 24-hour notice** of a cancellation, **you will be charged the full session fee for all late cancellations and missed appointments.** Please be aware that insurance companies will not cover cancellation charges.

By initialing here, you acknowledge that you have received a copy of the "Notice of Privacy Practices" and the "Patients' Rights and Responsibilities." _____

Patient/Legal Representative Signature

Date

Fee Agreement

Fees & Insurance: Fees (if you take insurance and I am a participating provider) are negotiated by your insurance company so normally you will pay a co-pay only. Sessions are normally 45 minutes in length. Letter writing, consultations with other professionals, telephone conversations, reading records or reports, travel time, longer sessions, etc. will be billed at the same rate as your therapy sessions. Returned checks are subject to a \$30 fee. This agreement supersedes all previously agreed to financial agreements and is effective as of the date signed. Patients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. Please be aware that not all issues/problems/conditions dealt with in therapy are covered by insurance. It is your responsibility to verify the specifics of your coverage. If you are using insurance, I will submit claims for you. You are responsible for any applicable deductibles and copays at the beginning of each session. You understand that insurance is billed as a courtesy to you and that **you are responsible for full payment if the insurance company denies the claim.**

If your account is overdue (unpaid) and there is no written agreement for a payment plan, I can use legal or other means (court, collection agencies, etc.) to obtain payment.

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Credit Card Authorization: I prefer to keep this information on file. However, it is not required.

I, _____, am authorizing Behavioral Innovations, LLC to charge the full session fee to the credit card indicated below in the event that I (or the patient, if services are being paid for by parent or other adult) fail to give 24 hours notice of cancellation of a scheduled

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appointment. I further authorize Behavioral Innovations, LLC to charge my credit card for any unpaid balances for services rendered that remain on the account. I also understand that this number will be stored safely for use with each visit's co-pay amount until I change cards, have completed my treatment, or decided that I no longer want to receive services.

Card Type (circle one): Visa Mastercard

Card Number: _____ Exp. Date _____

CVV code (3-digit code on back of card) _____

Name as printed on card _____ Billing zip code _____

Authorized cardholder signature _____ Date _____

I have read the above fee agreement document carefully, and I understand it and agree to all of its terms and conditions.

Patient or Guardian Signature

Date