Office Policy

Deborah S. Wilder, Ph.D.

Licensed Psychologist

Welcome to my practice. I hope that you will find an appropriate resolution to your particular concern in seeking my services. Please carefully read this information regarding general professional service guidelines and office policies. The intent of this disclosure is to promote an informed and appropriate professional relationship in the delivery of professional services. I encourage you to discuss with me any portion of this consent about which you have questions or concerns. The policies and practices listed in this consent form are also consistent with HIPPAA regulations

Professionalism and Confidentiality

By seeking clinical, consultation and/or evaluation services with me, you will be receiving treatment that is in accordance with the principles of appropriate clinical practice established by the American Psychological Association and the Georgia Psychological Association. During your treatment for your particular concern, please discuss with me any questions or concerns that you may have at any time. All contacts are held confidential under the laws of the state of Georgia. However, there are certain specific exceptions to confidentiality as determined by state and federal law. These exceptions are: (1) there exists a real and present threat of harm to self or to others, (2) suspected child or elder abuse, and (3) court-ordered disclosure. Please discuss with me any concerns that you have about these exceptions. Additionally, many "managed care" health insurance organizations utilize case management where disclosure of some clinical information is required before authorization of treatment is given. If you participate in such a "managed care" contract and have concerns about how case management may impact your right to confidential treatment, please discuss this with me and with your insurance carrier. The best practice model and ethical standards require that I consult with other professionals when it is appropriate.

If the person receiving treatment is under eighteen years of age, please be aware that the law provides parents/legal guardians with the right to information about the minor's treatment. Please also be advised if the client is a minor and his/her parent are divorced, it is your responsibility to inform the therapist of this as well as provide accurate and current information regarding custodial (physical and legal) arrangements as stated in your legal divorce agreement. If you are receiving marital or family therapy services, in most cases the "client" will be the joint couple, and not either individual. In other cases, the person being evaluated or receiving treatment is not the legal client and thus not entitled to legal privileged communication. If you have any questions about legal client status or the use of privileged communication, please discuss this with me.

_____ *Initial*

Scheduling

Many clients chose to schedule a specific appointment time in advance for a specified number of weeks, thus, not having to take any of their session time to schedule appointments. If you need to schedule over the telephone, call the office and leave a confidential voice mail message, and I will return your call at my earliest convenience. ***Since professional services are available only through prior scheduling and, therefore, time is reserved for your use only, sessions canceled less than 48 hours in advance are charged at the full rate of the scheduled service***. If you have two (2) consecutive missed appointments that you did not cancel or reschedule, all subsequent sessions already scheduled will be cancelled, and I reserve the right to terminate your treatment

with me at that time. Due to this professional relationship, exceptions are not made. The reason for the missed appointment does not alter this charge, which is not a reimbursable expense under most insurance policies. The 50-minute session will include all activities involved in the professional relationship. Thus, if you need to schedule your next appointment or make any financial arrangements, these activities will need to occur within the constraints of the 50-minute period. If you arrive late for your appointment, the session will still need to stop at the end of your scheduled time.

_____ *Initial*

I am available to be contacted after hours. However, if an emergency arises which requires immediate action, you should call 911 and/or go to the closest emergency room.

_____ *Initial*

Professional Fees

Professional fees are based on a $200 fee for a standard 50-minute outpatient session. If a session goes beyond the 50-minute time frame, an additional charge will be billed. Psychological assessments (non-forensic), consultations, and reports are billed at a $200 rate divisible by quarter-hour segments. Fees for frequent and/or clinically relevant telephone conversations (not related to scheduling or administrative issues) are billed at $50 per quarter-hour segment. Fees for the completion of patient requested forms or reports are billed at $50 per quarter-hour segment. Prior to any client information being released from this office in the form of a report, professional letter, or any other official documentation, payment must be made in full of any outstanding balance. Fees can be periodically adjusted, and while an attempt will be made to notify clients in advance of the adjustment, this may not be possible in all situations. Any service related to litigation, defense or other court-related activities will be assessed at a rate commensurate with the service needed. If you have need of these services, please ask for the appropriate separate document for these services and related fees. Any returned checks or charges will be assessed an office fee of $35 in addition to the fee imposed by the bank to process insufficient funds.

_____ *Initial*

Payment

Payment in full is expected at the time of services rendered. To serve the needs of some patients I am enrolled in Blue Cross/Blue Shield. Each managed care plan has different requirements. Thus, this office ultimately depends on you, the insured, to advise us on the requirements for your individual plan. Please check with your insurance company and advise me if your plan requires ***precertification*** before a service/session is delivered in this office. **Your contracted co-pay amount (and deductible if applicable) is required at the end of each session. Each client is personally responsible for all charges incurred, if your insurance carrier provides remuneration for such charges.**

_____ *Initial*

In order to avoid the accumulation of amounts due from you, you will be asked to complete and sign a *Credit Card authorization form*. This authorization will allow this office to charge your amounts due to your designated credit card at your request, or in situations in which your bill is past 15 days due. If your account is more than sixty days' delinquent this office retains the option to utilize a collection agency to obtain payment. .

If you decide to use your insurance coverage and/or you opt to communicate with this office via email, this office will utilize electronic means to conduct insurance transactions and to communicate with you. While

safeguards are in place for electronic communication and the submission of claims, this office cannot guarantee privacy for such communications.

Due to confidentiality reasons and to minimize the potential for interference with your session, please consider turning off cell phones or turning down the ringer volume at the beginning of your session. However, if you determine that you need to be available via your phone, please make sure that a call is not inadvertently made, thus potentially compromising your confidentiality.

If you are scheduled for marital therapy, BOTH marital/relational partners must sign and date the office policy, as the official "client" is neither individual but the marital/relational partnership.

_____ *Initial*

I have read and agree to this agreement for professional psychological services:

_____ _____/ /_____

Client's Signature Date

_____

Client's Printed Name

_____ _____/ /_____

Spouse's Signature (if marital/relational therapy) Date

_____ -

Spouse's Printed Name (if marital/relational therapy)

_____ _____/ /_____

Guardian's Signature (**if applicable**) Date

_____

Guardian's Printed Name (if applicable)