MINDFULLNESS

Welcome to Mindfullness! We feel privileged to have the opportunity to get to know you, and look forward to our work together.

Please review the following treatment information for outpatient psychotherapy treatment. Once completed, please sign at the bottom to indicate that you have reviewed this information. Feel free to ask any questions that may arise.

Fee Policies: If you are not in network, or paying privately, fees are as follows:
Initial consultations are an hour in length and cost $225.00.
Individual and family psychotherapy sessions are $200.00 (60 minutes) and $175.00 (45 minutes).
Group therapy is $50-75.00 an hour depending upon the group you are enrolled in.

Billing Procedures: We work with a certified billing specialist who will bill your insurance company for you. However, it is your responsibility to verify whether and to what extent your insurance company will reimburse for my services. Every insurance plan is different, and therefore I encourage you to talk with your provider about the rates in which they will reimburse. It is important for you to be familiar with your insurance company's conditions. The billing specialist will communicate as required with the insurance company and help you facilitate the process as necessary. You will be responsible for co-payments, fees not covered by your insurance, and fees related to your required deductible. A billing statement will be sent to you the first week of each month. **Your account balance is due at the beginning of the month. Please call or mail in payment or bring to your next scheduled session each month.**

Cancellation Policy: If you need to cancel an appointment please provide 24 hours advance notice (via e-mail or voicemail). We offer some flexibility as emergencies and illness arise for both client and therapist. However, if frequent last minute cancellations occur, you will be charged a $50.00 cancellation fee for the missed session. Please be aware that insurance carriers will not reimburse for missed session fees. Therefore, fees generated from a missed session will be your responsibility. Sessions your therapist needs to cancel due to emergency, illness, or other extenuating circumstances will be re-scheduled as soon as possible. You will be notified in advance regarding any planned absences. You will be provided with contact information for a therapist who is available to see you if necessary when your therapist is out of the office for a vacation or planned absence.

Confidentiality: Information you share with your therapist will be kept strictly confidential and will not be disclosed without your written consent. By law, confidentiality will not be guaranteed in life threatening situations involving yourself or others, or situations in which children are put at risk (such as physical or sexual abuse or neglect). All minors must have parental consent to be in treatment.

Phone/E-mail/Emergency Contact: Please do not hesitate to contact your therapist via telephone or e-mail. We make every attempt to return all communications within 48 hours. If it is an emergency, please do not wait to hear back from your therapist. In an emergency, proceed to your nearest emergency room or immediately call 911. The nature of an outpatient practice does not allow us to be on call and immediately responsive and available in emergency situations

Physician Contact/Nutritional Counseling: Physical and psychological symptoms often interact. Physical complications affecting those with eating disorders can be serious and life threatening. Treatment providing a multidisciplinary team approach offers the highest rate of success. For these reasons, it is likely medical evaluation and follow-up, nutritional counseling, and possibly medication, will be recommended for eating disorder treatment. Appropriate referrals and team coordination/communication will be provided.

Freedom to withdraw: You have the right to end therapy at any time. Referrals for additional providers will be provided by request.

Informed Consent: I have read and understand the preceding statements. I have received Privacy Policy information and understand the Privacy Policies. I have had an opportunity to ask questions about them. I agree to enter a psychotherapy relationship with a therapist at Mindfullness .

Patient Name (please print): _____ Date: _____

Patient Signature (if minor, parent/guardian signature is required): _____

Therapist Signature: _____ Date: _____