Dennis England Licensed Clinical Social Worker
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PATIENT INFORMATION & AGREEMENT

Welcome to my practice. This statement of office policy has been prepared to inform and protect both the client and the provider. Please read the items below and sign and date this form if you consent to the terms described. These terms are described in additional detail in the *Notice of Privacy Practices* and the *Office Policies and General Information: Agreement for Psychotherapy Services*, which are being provided for you to keep for future reference.

Appointments: When you make an appointment, a specific time is reserved for you. If you must cancel an appointment, please do so at least 24 hours in advance. Otherwise, you will be charged for the missed appointment. Please bear in mind that most insurers will not reimburse for missed sessions.

Confidentiality: The provider will keep client identification, information, and treatment details in the strictest confidence except when such confidentiality would constitute violation of ethical principles or state of federal laws. Such circumstances include, but are not limited to, danger or threats of harm to the client or others, and reported or suspected abuse or neglect of children and/or the elderly. Consultation with other professionals may occur as the provider deems necessary to ensure treatment effectiveness. Please see accompanying documents for extensive discussion of confidentiality and privacy practices.

Fees: The fee for an intake or initial session is $150.00. The fee for a standard 45-50 minute session is $100.00. Sessions 53+ minutes are $125. Payment is due at the time service is rendered.

Insurance: Services provided may be covered by medical insurance plans. If you wish to file for insurance reimbursement, I will assist you in any way I can. Please be aware, however, that any information received from your insurer prior to claim submission and review is not a guarantee of coverage, and that if claims should be denied, you are ultimately responsible for the charges incurred. I currently participate in several PPOs. If you are covered by an HMO or PPO for which I am not a provider, any services received will only be covered if you have out-of-network coverage. It is your responsibility to determine the specifics of your insurance coverage for these services. It is not my policy to accept the amount an insurance company may pay an out-of-network provider as payment in full if the amount is less than my regular fee.

Be sure to read your copies of the *Notice of Privacy Practices* and the *Office Policies and General Information: Agreement for Psychotherapy Services* for additional information on policies, confidentiality, insurance, emergency procedures, and other topics.

I, the undersigned, affirm that I have read and understand the above guidelines. I have received copies of the *Notice of Privacy Practices* and the *Office Policies and General Information: Agreement for Psychotherapy Services*. I further affirm that my signature below indicates consent to receive services for myself and/or my child at an initial session and for following sessions as I may request.

_____ Date: _____

Signature (Client or person having legal custody if client is a minor)