Business Policy

This statement contains information regarding my office policies. Please read them and if you have any questions, discuss them with me. Your signature at the bottom of this sheet signifies that you have read, understand and agree to abide by these policies.

Appointments Each session is approximately 45 minutes in length and the rate is $170.00. **Fees are to be paid at the time of service.** A statement can be provided upon request for your records or for you to submit to receive insurance reimbursement. Extended telephone calls or sessions are prorated according to the per session fee. Your appointment time is reserved for you. If you must cancel, please notify the office as soon as possible. You will be charged in full for the appointment for less than 24 hours notice. If you are filing claims for your visits with your insurance company, it is important that you know that insurance benefits do not extend to missed appointment charges. **Insurance** If you choose to file insurance claims for services, your insurance company may require information from the office records; please speak to me if you have concerns about this possibility. **Financial Arrangements** Visa and MasterCard payments are accepted for amounts over $50.00. There is a $20 charge for checks drawn on insufficient funds. **Termination** Termination (ending therapy) is an important part of the treatment process. It is best this be a joint decision so progress can be reviewed and expectations for the future can be discussed. If I cannot provide appropriate therapy for your treatment needs, if treatment goals that are mutually agreeable cannot be developed, if financial commitments are not honored, if you are not benefiting from therapy or if the therapy environment becomes unsafe, the therapeutic relationship will be terminated. Any nonvoluntary termination will be accompanied by an appropriate referral for mental health services. A case will be identified as voluntarily closed after mutual discussion between therapist and client(s) or if there has been no contact for 60 days. **Availability** I am available to return routine and urgent calls within 24 hours. If emergency mental health services are needed and I am not available to contact you immediately, call the emergency mental health number in your county, go directly to the closest emergency room or call 911. I will arrange for coverage by another licensed clinician in the event I am unavailable for an extended period of time during business hours or after hours. There is a 24-hour voicemail and answering service seven days a week, so messages can be left at any time. **Confidentiality and the Release of Information** Your participation in treatment and all information about you is confidential and will not be disclosed to anyone without your written consent. Exceptions are: 1) Cases of suspected abuse or neglect of a child or elder and 2) Cases where the client presents a clear and imminent danger to him/herself or to another person. Other circumstances in which *you* may waive your right to confidentiality include a) the use of health insurance b) releasing information to another professional (e.g. physician, agency) and c) legal proceedings which involve information about your mental health.

My signature indicates that I have read and understand these policies.

_____ _____

Signature of Client (or Guardian) ***Date***

Colleen J. Taylor, Ph.D. www.PeopleGrowing.com

(02/13)

Date: _____/_____/_____

Colleen J. Taylor,
Ph.D. www.PeopleGrowing.com

CLIENT INFORMATION SHEET

Name _____ Birthdate _____/_____/_____
Age_____ Marital Status: Single Married Separated Divorced

Address_____
City/State/Zip _____ Home Phone _____

Cell/Work Phone _____ Education _____

Email Address (if you wish to be contacted by email) _____

Occupation _____

Employer's Name _____

Name of your Primary Care Physician _____

Referred By: Physician _____ Therapist _____
(please circle) Friend Dr. Taylor's Website Internet Search Other _____

Other people living in the home:

Name	Age	Relationship to Client

SPOUSE OR PARENT INFORMATION

Name _____ Age _____

Address _____
City/State/Zip _____ Phone _____
Occupation _____ Employer _____
Education _____

Nearest Relative or Close Friend Not Living With You:

Name _____ Address _____
Phone _____ Cell/Work Phone _____

09/14