Kera Glazer-Rosoff, Ph.D.

Clinical Psychologist PSY16120

OFFICE POLICIES

I am pleased that you have chosen to come to me for professional assistance. To acquaint you with my office policies, the following information is presented so that our work together will be mutually productive and beneficial.

Length of Sessions

Regular sessions are 45 minutes in length on a once weekly basis, unless otherwise arranged. Being prepared and on time at the beginning of each session will ensure that you receive the full benefit from your time.

Cancelling/Rescheduling Appointments

The scheduled appointment time is reserved exclusively for you. Every attempt will be made to adhere to a regular day and time so that you may plan your other activities. Consistency is essential for effective treatment. If a scheduling conflict occurs, it is your responsibility to cancel your appointment a minimum of 24 hours in advance. Otherwise, you will be charged half of the full session fee for the missed appointment. Understandably, emergencies do arise, and in such instances every attempt will be made to reschedule your appointment as soon as possible.

Termination

As therapy comes to a conclusion, it is important to achieve some closure. The appropriate length of termination is dependent on the length and intensity of the treatment. I may terminate treatment after discussion with you if I believe that the psychotherapy is not being effectively used or if you are in default on payment. Treatment will be terminated after three consecutive missed appointments. I will not terminate therapy without first attempting to discuss and explore the reasons and purpose of terminating.

Therapy

Therapy may help you in many ways such as the resolution of problems, stress reduction, improved social functioning, and improved self-insight. Therapy can often involve a large commitment of time, money, and energy, so you should be very careful about the therapist you select. Should we find that we are incompatible to successfully engage in therapy, I will be happy to offer referrals to other mental health professionals to assist you.

Referrals

Referrals will be provided as necessary. If a referral to another professional is made, I will work with them to collaborate and coordinate your care, and will request your permission to discuss your case with them. I make every effort to select extremely high quality professionals who ascribe to the highest standards of care. However, I can take no responsibility for the treatment they provide. It is up to you to determine if a professional I have referred you to is right for you, and the referred professional alone is responsible for the care they provide.

Fee Payment

Payment for services is required at each meeting, unless other financial arrangements have been made. Please understand that checks returned by the bank will not be re-deposited and will incur an additional

charge. It is important that any questions you have regarding fees and payment be discussed openly so that they will not interfere with the professional services you have sought.

My fee for a regular session is $200.00. For those on Medicare, services will be provided at Medicare's rate of reimbursement.

Initials: _____

Insurance

I am not part of any insurance panels other than Medicare, and I am considered an "out-of-network" provider. If you have a health benefits policy, it will usually provide some mental health coverage. However, you, not your insurance company, are responsible for full payment of the session fees at the time of the appointment. I *do not bill your insurance* directly. Should you elect to pursue reimbursement from your insurance company for my services, I will provide you with a billing statement ("Superbill") that you may submit.

I understand that for non-Medicare clients, I am fully responsible for full payment of the session fees at the time of service.

Initials: _____

For Medicare patients only, please be aware that I may utilize the services of an outside billing agency to collect fees. This entails the use of electronic communication (e-mail) of limited patient information. The information includes your name, diagnosis, and dates seen.

I authorize the release of limited medical information to my insurance company(ies), as required for payment of services and/or for additional session approval. I further authorize payment of insurance benefits, directly to Kera Glazer-Rosoff, Ph.D. for all services provided.

Initials: _____

Telephone Messages/Emergencies

Should you need to contact me by telephone in between your scheduled appointments, you may leave a message on my voicemail system. Include a telephone number and times when you may be reached, and an attempt will be made to respond within 24 hours. In the event of an emergency, every effort will be made to respond as soon as possible. If the emergency requires an immediate response, please dial 911. When I am out of town or otherwise unavailable, a qualified professional will be available to cover for me.

ELECTRONIC MAIL AND TEXT

Please be aware that e-mail and texts are *not* confidential means of communication. Also, I cannot ensure that email or texts will be checked daily. These are not the appropriate ways to communicate confidential information or emergency issues. E-mail and texts are appropriate for brief and uncomplicated updates, questions, or appointment scheduling.

Please initial all that apply:

_____ I have the right to refuse any treatment.

_____ I have the right to discuss all treatments with my provider.

The above policies have been developed for our mutual benefit, with the intent to avoid any disagreement or misunderstanding that might interfere with our professional relationship. Please feel free to discuss any questions that you might have with me at any time.

Your signature below verifies that you have carefully read, fully understand, and agree to these policies. Should you have a dependent child or adult in my care your consent is applicable for the services they receive.

_____

Client Name (Print)

_____

Name of Responsible Party (if under 18 or cared for by a legal guardian)

_____

Signature of Client or Responsible Party (if under 18 or cared for by a legal guardian)

_____/_____/_____

Date