GREAT LAKES PSYCHOLOGICAL SERVICES - IMPORTANT POLICIES

I, _________________________, hereby give consent to participate in psychological treatment for myself or for my child, ______________________________, with **Sandra Pfander, Psy.D**.
I understand that emergency treatment is not available and treatment is by appointment only. If there is an emergency, please go immediately to the nearest emergency room or call 911.

Please call our office for specific information regarding fees for psychotherapy and testing services.
I understand that payment for services is **due on the date of service**. I agree to **pay my co-pay in full at each visit**, including any payment toward my deductible if I have one. I understand that I must provide updated insurance information, including any secondary insurance, and notify the office of changes in insurance immediately. Insurance benefit information provided by this office is NOT a guarantee of benefit payment. I understand that **I am responsible** for charges not covered by my insurance.

I understand **I will be charged a $100 NO SHOW FEE for a missed session if I fail to show for an appointment.** I understand that **if I cancel an appointment without at least 24 hours notice or without a valid reason (illness or emergency), I will be charged a $50 LATE CANCELLATION FEE.**
I understand that time in my psychologist's schedule has been set aside exclusively for my appointment, and repeated missed appointments or late cancellations on my part may result in future appointments no longer being rescheduled. I understand that my insurance will not cover the charge for a no-show or late-cancelled appointment. **As a COURTESY to you, our office staff will try to send reminder texts as time allows**, but you are ultimately responsible for keeping track of your appointments.

I understand that all accounts past due for 30 days or more will be considered **delinquent** and subject to a $25.00/month late fee. I understand that I may be charged for unreturned books that have been loaned to me. Appointments may not be scheduled for patients with delinquent accounts. If a payment plan is necessary, please discuss this arrangement prior to your appointment. Delinquent accounts may be turned over to a collection agency. Checks returned for insufficient funds will incur a $30.00 fee, in addition to any bank fees incurred. Cash or charge will be required for future payments.

All psychologists and office staff must respect the confidentiality of patient files. Verbal and/or written material pertaining to any patient is never to leave the office without a signed release expressly permitting that to happen or as required by law. If you have questions regarding any of the above policies, please do not hesitate to discuss it with us.

_______________________________________ _________________________

Parent/Guardian Signature **Date**