DRS. GAULT, FISHBEIN, & ASSOCIATES

Jeffrey A. Fishbein, Psy.D., PC
Licensed Clinical Psychologist

POLICIES

I am pleased to have the opportunity to work with you. This document contains very important information about my policies and procedures. Please read and sign where indicated.

PAYMENT:

Payment in full is expected at the time of service, or according to a mutually agreed upon schedule. In addition to weekly appointments, I charge for other professional services you may need, such as report writing, telephone conversations, email dialogues, attendance at meetings with other professionals that you have authorized, preparation of records or treatment summaries, and time spent performing any other service you may request. Regardless of our agreed upon payment schedule, your account is expected to be paid in full by the end of each month. I accept cash or checks.

EMAIL AND TELEPHONE CONTACT:

I charge for *any* email and telephone contact that is of a clinical nature. I encourage updates and information about you or your child. However, the time I spend reading emails of a clinical nature or speaking with you on the phone about clinical issues is time that I am performing my role as a psychologist. There will be a minimum charge of $25.00 for this type of correspondence. Charges beyond the $25.00 contact fee will be based and prorated on my session rate.

CANCELLATION POLICY:

Once an appointment is scheduled, I will be enforcing a strict *24-hour policy* for cancellation. This reasonable prior notice of cancellations permits me to better accommodate other patient's needs. Except in cases of family/medical emergency and illness, and severe weather, appointments cancelled within the allotted time period will be charged full fee for the appointment. This will be non-negotiable. These fees are not covered by health insurance and are the patient's personal responsibility.

PRIVACY:

The privacy of all records pertaining to your treatment will be maintained securely. Records will be kept for a minimum of seven years, will be used only for appropriate treatment purposes, and will be released only with your specific written consent or authorization, as provided for by Illinois and Federal law. You have the right to review your records (including the record of disclosures made). I will make copies available to you upon your written request and will charge a reasonable fee for copying records requested by you. If at any time you feel your privacy has been violated, you have the right to file a grievance with me and/or with the Secretary of the U.S. Department of Health and Human Services. Note, however, that the law requires the release of otherwise confidential information when the provider reasonably believes disclosure is necessary to protect against harm to yourself or others, when there is suspicion of child or elder abuse, and when records are demanded by Court Order.

TREATMENT OF MINOR CHILDREN OF SEPARATED OR DIVORCED PARENTS:

If treatment is sought for a minor child of divorced or separated parents (or for any person whose **guardianship** has been settled by Order of Court), my office *must* have on file a copy of the divorce decree or other Court Order specifying the terms of custody, visitation and guardianship, particularly regarding guardianship for healthcare. I must receive consent in advance for my services (both evaluation and treatment) from a party legally authorized to give consent for healthcare services. Payments of fees to my office will be the sole responsibility of the parent or guardian signing here as "responsible person" notwithstanding any court order or decree assigning financial responsibility for healthcare to any other party. (Reimbursement from any other such party – e.g., co-parent – to the payee for payments made to us must be arranged directly by the signing "responsible person.) My office cannot bill such third parties.

INSURANCE REIMBURSEMENT:

Most health insurance policies will cover some portion of mental health treatment. I do not participate as an "in-network" provider. I will be happy to help you understand any questions you may have regarding your policy. However, I do not submit bills to insurance companies, and you (not your insurance company) are responsible for full payment of our fees.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS:

During the course of treatment, I often use email, fax, or other forms of electronic communication. These methods are generally not known as confidential means of communication. Therefore, your signature below authorizes such forms to be transmitted, including but not limited to, information related to: scheduling, billing and invoicing, payments, and other clinical or administrative issues.

I, _____ AUTHORIZE: Dr. Jeffrey A. Fishbein, Psy.D., PC

Patient or Parent/Guardian if patient under the age of 18

to transmit the protected health information listed above. This authorization will terminate after treatment has been terminated and file is closed.

_____

SIGNATURE

CREDIT CARD INFORMATION:

I use credit cards *for outstanding debt and "collection" purposes only.* Any outstanding balance that goes unpaid for over 60 days, *after request via email to be paid*, will be charged to the credit card number below. Your signature below authorizes me to charge this credit card for unpaid balances. If a credit card is used for any purpose, there will be a 3% fee added.

CC #: _____ CARD TYPE: AMEX VISA MC

NAME ON CARD: _____ EXP: _____ SECURITY CODE: _____

_____

SIGNATURE OF CARDHOLDER

THANK YOU

If you have any questions about any of my policies, please do not hesitate to ask me. Please sign below indicating you have read and understand this policy and agree to abide by its terms.

Name of Patient: _____/_____/_____

(18 yrs or older) Print Name Signature Date

Name of Parent: _____/_____/_____

Print Name Signature Date