Fishbein & Associates
Performance Consulting

www.dr-fishbein.com

POLICIES

We are pleased to have the opportunity to work with you. This document contains very important information about our 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, we 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. We accept cash or checks.

EMAIL AND TELEPHONE CONTACT:

We charge for *any* email and telephone contact that is of "session" nature. We encourage updates and information about you or your child. However, the time we spend reading emails of this nature or speaking with you on the phone about such issues is time that we are performing our role. 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 our session rate.

CANCELLATION POLICY:

Once an appointment is scheduled, we will be enforcing a strict *24-hour policy* for cancellation. This reasonable prior notice of cancellations permits us to better accommodate other client'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 client's personal responsibility.

INSURANCE REIMBURSEMENT:

Health insurance policies do not cover sport psychological services. However, if there is a pre-existing diagnosis and part of the "treatment" relates to that diagnosis, we will provide you with a bill you can submit to your insurance company. Regardless, you (not your insurance company) are responsible for full payment of my fees.

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

During the course of treatment, we 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: **FISHBEIN & ASSOCIATES PERFORMANCE CONSULTING**
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

THANK YOU:

If you have any questions about any of our policies, please do not hesitate to ask. 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