R. PATRICK SAVAGE, JR., PH.D., ABMP & Associates
17101 Thatcher Court
Olney, Md. 20832
www.olneynorthbethesdapsychology.com Telephone 301-587-2818

OFFICE POLICIES & PROCEDURES

Please Read ~ You will be asked to sign this form ~

Introduction

We appreciate your selection of our office to work with you in addressing your mental health needs. Since people come to us with different expectations, we would like to acquaint you with our policies and procedures. We ask that you familiarize yourself with them and *feel free to let us know if you have any questions regarding them.* ***Your signature on the back of this form indicates that you understand and accept these policies as the basis of our relationship.***

Services Rendered

We offer a full range of psychological and psychotherapeutic services. These include, but are not limited to, individual therapy, group therapy, couples therapy, and family therapy which all include a wide range of therapeutic issues. In addition we offer psycho-diagnostic, psycho-educational, neuropsychological evaluations, forensic psychological and neuropsychological evaluations as well as sports concussion management (ImPACT testing) and safe return to play. Services are rendered to adults, adolescents and children.

NOT ALL SERVICES ARE A COVERED BENEFIT. Additional services such as review of medical records and reports, phone consultations, school visitation, extended or double therapy sessions, certain test batteries and extended report writing, completing forms, letters etc. are be billed at the individual therapy rate. If your therapist engages in forensic work, charges for these services are separate and are to be discussed with your therapist.

Benefits and Emotional Risks:

The vast majority of people who seek therapy or evaluation services benefit in leading more fulfilling and content lives as a result of these services. However, some risks exist including experiencing difficulty or uncomfortable feelings as you address the issues that have led you to seek therapeutic services. Your therapist will work with you to establish treatment goals and work with you towards the achievement of those goals. However, therapy is work and requires your effort in order to achieve your goals. There are no guarantees about what might happen in therapy, or that you will achieve your goals. Therefore, you are always an active participant in this process and invited to discuss any concerns you might have as therapy progresses or during the evaluation process.

Client Privacy

Your privacy and confidentiality are the basis of building trust, critical to successful therapy, and legally protected. Exceptions to confidentiality exist when: 1.) Your therapist believes that your life or your child's life is in imminent danger, 2.) Your therapist believes that you or your child is an imminent danger; or 3.) If an adult, child, elder, or disabled person has been or is suspected of being abused. In all other circumstances a written release is required for communication to third parties. At times, your therapist will ask or you may request oral permission to facilitate a solution for you, this can be honored but will be followed up by a request for written consent.

Appointments

All clients are seen by appointment only. Your Therapist/Practice Administrator will assist you in scheduling your appointments at a mutually agreeable time. Individual, family and couples therapy sessions are 45 minutes in duration. Group therapy sessions are 75 minutes. In order to assist you in scheduling your time, every attempt is made to begin and end therapy sessions on time. If you are late for a session, that time is lost from that session. If your therapist is late, you will receive your full session or other arrangements can be made as long as they are mutually agreed upon.

Psychological / Neuropsychological Testing

Testing is made by arrangements with your Therapist/Practice Administrator. Insurance companies may cover

a varying percent of the cost of an evaluation. *You should check with your insurance so that you are aware of any special pre authorizations that they require in order to pay a portion of the cost.* Written reports are provided to you and to other professionals with whom you consent to share the results once the costs of the evaluation are paid in full. *A 50% deposit is required before testing will be scheduled*.

Cancellations and Missed Appointments*

Time is specifically reserved for you and will not be offered to anyone else. Therefore, when your appointment is scheduled, you are responsible for the fee for that appointment. This includes both individually scheduled, weekly appointments and scheduled testing dates. If you are unable to keep your appointment, please notify the Practice Administrator as far in advance as possible. *If it is possible for your time to be filled with someone else or, if a mutually agreeable substitute time during that same week can be arranged, then you will not be charged for the initially scheduled appointment time.* If your therapist cancels your appointment no charge is incurred to you.

It should be assumed that appointments will be held in all types of weather unless notified by your Therapist. In the event that you have concerns about a specific appointment or situation, please discuss this with your Therapist**. You may also call the main answering service 301-587-2818 and listen to your Therapist's message which will provide you with information about scheduled appointments in unusual circumstances.**

Communication with the Office

Clear and accurate communication is at the basis of all successful human relationships. We have established these policies to provide and promote clear communication with you our clients.

Telephone Communication

Our telephone policies are meant to allow us to care for our clients with a minimum of interruptions during scheduled appointments. If you have issues or information that cannot wait until your next scheduled appointment, you may call and leave a message for your Therapist that they will make every attempt to return in a timely manner. Emergency telephone calls will be handled immediately and calls which are less urgent will be handled as soon as possible, usually within 24 hours on Monday through Thursday. In the event of a true life threatening emergency, please call the main answering service (**301-587-2818**) in order to reach your Therapist and follow the instructions for an emergency. In the event that your Therapist is unavailable there will be a Therapist on call. If the situation is life threatening and you cannot wait or reach your therapist, please proceed to the nearest hospital emergency room.

Appointment scheduling and management is done through the Practice Administrator, whom you can reach at either **301-587-2818** or **301-774-0575** Monday through Thursday from 9am to 5pm.

E-mail Communication

In order to protect your privacy, e-mail is **not** regularly used as a form of communication. Your Therapist/Practice Administrator can make specific individual arrangements with you through an encrypted e-mail service that offers the best available protection of your privacy to receive and/or send specifically agreed upon information.

Professional Records

Your Therapist is required by both law and professional standards to keep treatment records. On occasion a client may request to see your record. Since these are professional records, they can be misinterpreted and contain information that may be harmful to you. If I believe this to be the case, I will provide you with a summary of your record. It is usually best that this summary be reviewed with you so that any questions you might have or issues that require clarification can be fully discussed prior to the release of the summary.

Fees & Insurance

We recognize the need for a definite understanding between you the client and his/her therapist regarding the financial arrangements for services rendered. The responsibility for payment of these fees is the direct obligation of the client. ***Payment is due at the time services are rendered unless other arrangements have been made.***

We do not participate with or accept direct insurance payment for services rendered. **It is, therefore, your responsibility to submit claims on your behalf and to communicate directly with your insurance company regarding your benefits and reimbursements.** Our office will provide you with a universal insurance claim form on a monthly basis. These forms are designed for submission to insurance companies. If additional information is required, do not hesitate to let us know. *We are happy to help you receive your maximum allowable benefits*.

The Client_____ &/or Designee_____hereby retains Dr. Savage to provide psychological/counseling/evaluation services for:_____: Furthermore, the Client/Designee (parent, guardian, or other representative) agrees to pay for these services at a rate of $_____per sessions for individual or family therapy, and $_____per session for group therapy/counseling. The Client/Designee agrees to pay for additional services such as collateral consultations, report preparation, school visitation and extensive telephone calls at the individual therapy rate. If I provide forensic services, Fees for legal services (reports, depositions, consultations, testimony, review of records, etc.) are billed at $_____ per hour. The undersigned shall be responsible for payments relating to any of the above whether they are requested by the undersigned or necessitated by subpoena or other Court process, even though not at the request of the undersigned. The Client/Designee further agrees to pay for missed or canceled appointments per the aforementioned policy. The Client/Designee agrees that he/she is personally liable for the fees incurred and any insurance reimbursement will be paid to the Client/Designee unless otherwise arranged and noted below. If you are utilizing managed care, you are responsible for your co-payments and any additional charges for services rendered, that we agree you wish to receive, that are not payed by your insurer. I also reserve the right to alter your fees. However, if this were to occur, you would be given 30 days notification of any changes in your fees.

Schedule Of Payment

1. **Payment:** All sums due to Dr. Savage shall be paid by the Client/Designee at the time services are rendered unless otherwise arranged and noted below. If you agree to receive services that are not covered by your insurance company ie. extended counseling, psychoeducational testing, letters, phone consultations etc. you agree to be fully responsible for payment of those services.

2. **Late Charge:** ***Late payments in violation of the payment agreement or not payed by the end of the month after receiving our bill will be subject to a finance charge of 1% per month.***

3. **Failure to Pay:** The Client/Designee agrees that failure to pay for services as agreed herein may, at the discretion of Dr. Savage, be construed as a discharge of the mental health professional. The Client/Designee further agrees that in the event collection action becomes necessary to collect any money due under this Agreement, Client/Designee agrees to pay an additional amount due (up to 32% of the balance due), as collection fees, attorney's fees, as well as costs of any suit. Client/Designee further agrees and consents to suit being filed in Montgomery County, Maryland, and waives any right to claim improper jurisdiction and/or venue. Should collection of your account become necessary, a release of information as stated below, would only occur fifteen (15) days after written notice is sent to your last known address. Although the content of communications between you and your therapist is confidential, it will be necessary to release to the collection source (e.g. collection service, attorney, etc.) your name, business and home addresses, telephone numbers, amount due, and the nature of the services that you received from Dr. Savage.

Acknowledgment: Client and Designee acknowledges they have received, read, and consented to the conditions stated herein.

_____ ___/___/___ _____ ___/___/___
Client (Date) Client (Date)

_____ ___/___/___ _____ ___/___/___
Designee (Date) Designee (Date)

I, the therapist, have reviewed and discussed the issues above with the Client/Designee (his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ ___/___/___
Signature of Therapist (Date)