STATEMENT OF UNDERSTANDING *Effective September 2009*

Richard H. Stout, MS, LMHC, Licensed Psychotherapist

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Welcome to the office of Richard H. Stout, MS, LMHC, Florida Licensed Psychotherapist. Our primary focus is to provide a safe, confidential and therapeutic environment in which you may effectively and efficiently deal with your issues. With this goal in mind, and to eliminate any misunderstandings, the following are general practice guidelines for your review and signature. Suggestions and/or questions are welcomed anytime. Thank you for the opportunity to participate in your care.

PRACTICE GUIDELINES

I understand that the first office visit is purely for evaluation purposes. Further, I understand I am responsible for payment of services rendered, regardless of whether that service is covered by an insurance policy, and I agree to pay these costs regardless of any disputes with my Insurance Company. (It is our pleasure to bill your Insurance or EAP as a courtesy, but final payment for our services are ultimately your responsibility.) **I understand that past due debts are forwarded to a Medical Collection Agency for recovery.**

While I expect to benefit from this treatment, I fully understand that due to factors beyond our control, particular outcomes cannot be guaranteed. I understand and agree that my consistent and regular attendance, along with compliance with treatment assignments and recommendations will produce the maximum benefits. I have the right to ask any questions about my care.

I/we understand I/we am/are free to discontinue treatment at any time. If I decide to do so, I will notify this office at least two (2) weeks in advance so that effective treatment planning for continued care can be implemented.

FINANCIAL ARRANGEMENT AND BILLING POLICIES

Initial Evaluations are billed at $150 and subsequent Therapy Sessions are billed at $100 per 45-50 minute ‘clinical hour‘.
Therapy in other time durations, report /letter writing and/or crisis calls are pro-rated at the rate of $100 per ‘clinical hour’.

I understand that I **will be billed for appointments not cancelled 24 hours prior to the appointment time.** Further, I understand that “No Shows” may result in termination of Counseling services with this office.

Our practice contracts with many Insurance Companies, in many cases offering ‘in network’ negotiated rates. In order to utilize any special rates, **it is often necessary for you to obtain PRE-AUTHORIZATION** through your Insurance Company. Please be prepared to bring this information with you to your first session. In most cases, we are pleased to file an insurance claim for you, but ultimately, any pre-certification, verification, and/or payment of any copay/deductible amount is the **patient’s responsibility. We request co-pays or deductibles be paid at time of each session. Effective September 2009 our billing office will add a $1.00 administration fee to each session fee that requires a statement to be mailed.**

MESSAGES

You will notice I do not accept phone calls during therapy sessions At those and other times of the day and evening, calls are answered either by office staff or the answering service. I am notified of all calls and make every attempt to return all calls in a timely manner. If we anticipate greater availability is necessary, special arrangements can be made for additional therapeutic services.

CONFIDENTIALITY

No one will reveal information concerning your psychotherapy care, except as follows: (1) You consent in writing, (2) Your life or safety is threatened, (3) disclosure is required by law, or (4) information is required by your Insurance Co. regarding a claim for our services. ANY AND ALL INFORMATION - PERSONAL, MEDICAL OR OTHERWISE - WILL BE HELD IN THE STRICTEST CONFIDENCE.

I have read and understand this Statement of Understanding, and will abide by all the above guidelines.

A copy of this signed sheet will be provided to me upon request.

Patient Signature: ______________________________ **Date:** ______________

Witness: ____________________________________ **Date :** ______________

Turn Over Please