The Center for Mindful Exploration, LLC

Susan Marshall, LPC

2018 OFFICE POLICIES AND PROCEDURES

The policies and procedures of this office have been created in an effort to improve service and to minimize inconvenience to our patients. It is my hope that by familiarizing you with these policies in advance, we may prevent misunderstanding and potential confusion or other difficulties.

OFFICE HOURS: My office hours are from 8:00 A.M. until 6:00 P.M. Tuesday through Thursday. My phone number is 706-333-2879. I am generally in session, but you can leave your name, number and message and I will return your call within two business days.

APPOINTMENTS: Visits are by appointment only. However, if an urgent need should arise, I will make every effort to see you that day if possible. If you are unable to wait for a call back or your need is emergent, please proceed to your nearest hospital emergency department or call 91 1 for any potential life-threatening event. You can also call the Georgia Crisis Line at 800-715-4225.

TREATMENT EXPECTATIONS: Many things affect the success of treatment. The severity of the problem, the match between the doctor/clinician and patient, and the motivation of the patient among other factors affect the length of treatment. We can discuss your feelings about your treatment and whether it is meeting your needs at any time.

Typically, the decision to terminate therapy is made by mutual consent of clinician and patient. In the event that you decide to discontinue treatment without notifying your clinician, it is assumed and formally agreed upon that the therapeutic relationship terminates 30 days after your last visit.

CONSENT TO TREAT: I give consent to Susan. Marshall, LPC to provide any mental health/substance abuse care deemed necessary to accurately diagnose and treat my condition.

FEES: Initial appointments and family/ couples sessions are 60. Individual sessions are generally 45 minutes. I will provide a fee schedule for you upon request. If you need to cancel an appointment, TWENTY-FOUR HOURS ADVANCE NOTICE will be required. This allows us time to schedule another patient for that period. A CANCELLATION CHARGE OF $50 WILL BE MADE FOR MISSED APPOINTMENTS WITHOUT A TWENTY-FOUR HOUR NOTICE OF CANCELLATION in that the time period was reserved for your usage and may not be able to be refilled on such short notice. Payment in full is required at the time of service unless other arrangements have been made in advance. A thirty-five dollar service charge will be made for all returned checks.

_____ _____

Patient Name Social Security #

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Date of Birth

INSURANCE POLICIES: Please be aware that some insurance companies require the insured patient to contact them in advance of any scheduled visit to obtain pre-authorization for services. You are solely responsible for meeting this or any other obligation of your contract with your insurance company prior to the time of your visit. Your insurance co-payments and deductible fees are required in full at the time of service,

Your insurance coverage is a contract between you and your insurance company. As a courtesy to you, I will be happy to file a claim for your visit on your behalf**. The ultimate responsibility for payment, however, remains with you.** Accordingly, any account balance over thirty (30) days old will be billed directly to you. Should your account have to be collected through a collection agency or an attorney, you shall also be responsible for all reasonable attorney's fees and all costs of collection. Please be aware that all unpaid balances will be referred to a collection agency if you fail to fulfill your financial obligations.

A photocopy of this form shall be considered as effective and valid as the original. Please read this information carefully and discuss any questions you may have.

A copy of this form is available for your records

.I have fully read, understand, and agree to the above policies and consent.

Patient/Guardian Signature _____ Date_____

Printed Name of Patient or Guardian:_____