Long Island Cognitive Wellness Counseling Services, LCSW, P.C.
Lianne E. Conroy, LCSW-R
269 West Main Street, Bay Shore, NY 11706
631-913-8201
lconroylcsw@gmail.com
www.licognitivewellness.com

OFFICE POLICIES – EFFECTIVE JULY 1, 2016

The usual and customary fee for this office is _____ per session.

If paying out-of-pocket, the payment of the full session fee is required at the time when services are rendered. This office does not submit requests for out-of-network benefits directly to insurance companies on behalf of our clients. If you would like to submit these requests independently, we can provide you with proper documentation. Please note that payment for services is not contingent upon reimbursement from your insurance company.

If using insurance, you are responsible for all out-of-pocket costs associated with your plan, including regular copayments, deductibles, and coinsurance amounts. Your copayment amount of _____ is due at the time that services are rendered. Please note that it is your responsibility to notify this office of any changes to your insurance coverage.

If you are unable to keep a scheduled appointment, kindly cancel the appointment with at least 24 hours notice. Cancelling an appointment (for a non-emergency reason) with less than 24 hours notice will result in a $50 fee. If you must cancel an appointment within 24 hours of the scheduled meeting time, please contact your clinician directly.

If you do not show up to a scheduled appointment – "no show" – you will be responsible for the full fee of a session. The slot allotted to you in the schedule has been designated for your session; therefore, you must pay for the spot even if it is not utilized.

In the event that a payment is returned due to insufficient funds, you are responsible to pay for any bank fees incurred before your next session.

If a balance of $100 or more in copays/session fees occurs, an appointment cannot be scheduled until that fee is paid.

I, _____, have read, understand, and agree to adhere to the above policies.

Signature: _____ Date: _____

Witness: _____ Date: _____

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CREDIT CARD INFORMATION - REQUIRED

In adherence with our office policies, we require that all clients leave a credit card on file.

CARDHOLDER'S NAME: _____ ZIP CODE: _____

CARD TYPE: _____ EXP DATE: _____

CARD #: _____ SEC CODE: _____

Please review the following and <u>initial</u> to the left of each statement.

_____ I would like this card to be used as the primary mode of payment for all session fees or copayments. _____ YES _____NO

_____ I understand that this card will be charged a $50 fee any time I cancel an appointment less than 24 hours before the scheduled meeting time.

_____ I understand that if I fail to attend a session and do not notify my clinician or the office, the full fee for the session will be charged to this card.

_____ I understand that this card will be charged for any outstanding balances over $100.00.

Signature: _____ Date: _____

Witness: _____ Date: _____

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NOTICE OF CONFIDENTIALITY

Your participation in therapy, the content of our sessions, and any information you provide to me during our sessions is protected by legal confidentiality. Your treatment is kept in the strictest of confidence. I will not share information or discuss anything about you, your treatment, or your progress with any family members or physicians, or any other individuals or groups without written permission from you. There are only a few instances in which this confidentiality may be breached. These instances include:

- **SAFETY CONCERNS:**
  I reserve the right to breach confidentiality if I reasonably believe that disclosure of confidential information will avoid or minimize an imminent danger to your health or safety or the health or safety of any other individual.

- **ABUSE:**
  I am legally mandated to report any instances of abuse toward children or vulnerable adults.

- **LEGAL SUBPOENAE**:
  If a valid subpoena from a Court of Law is presented to me, I am legally mandated to adhere to the request.

- **INSURANCE AUTHORIZATION:**
  I may share information regarding your symptoms, treatment, or progress to your insurance company if the company requests and requires the information in order to (1) grant authorization for continued treatment, and/or (2) provide payment for services rendered.

- **LEGAL DISPUTE:**
  A decision to bring legal action against me may result in a waiver of certain aspects of the confidentiality agreement.

In the event that your confidentiality is to be breached, my office will make reasonable attempts to contact you and discuss the situation beforehand. If you have any questions regarding this document or your confidentiality rights, please ask as soon as possible. This will help us prevent confusion, ensure that the agreement is clear, and enable us to build a good relationship based on trust.

This document reflects an active interest in your concerns and care. Upon your signature below, you indicate that you understand and agree to all points of this document.

Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 requires that healthcare providers give patients a copy of the office Notice of Privacy Practices and make a good faith effort to obtain an acknowledgement of receipt of the same. You may refuse to sign this acknowledgement form.

By signing this form, I confirm that I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Sign Name: _____

Date: _____

FOR OFFICE USE ONLY

Written acknowledgement was not obtained:

_____ Patient refused to sign

_____ Emergency situation

_____ Unable to communicate with patient

_____ Other: _____

_____

_____

_____

_____