Practice Policies

It is important for patients and therapists to have a clear understanding of the general policies and procedures that govern their work together. I am, therefore, describing these policies to allow our joint efforts to proceed smoothly and efficiently.

1. There will be an initial consultation/evaluation session to determine the nature and best approach toward resolving the problems to be addressed. At the end of the consultation we will agree upon a mutually convenient day and time to conduct our sessions. Once these arrangements are made, that time slot will be reserved for you, and cannot be available to any other patient. Missed sessions may necessitate a change in appointment time. ***ANY SCHEDULING CHANGES MUST BE MADE AT LEAST 24 HOURS PRIOR TO OUR SCHEDULED SESSION***. If 24-hour prior notice is not received, you will be responsible for paying the session fee as I am unable to see any other patients in the time I have reserved for you. You should be aware that insurance companies cannot be billed for, and will not pay for missed sessions. You may be charged both your co-payment and insurance fee. If my schedule permits, I will try to provide an alternative appointment during the week that is mutually agreeable.

2. The sessions are forty-five (45) minutes long. Every effort will be made to start and end on time. All fees must be paid in full at the time of the session unless alternate arrangements are made. Payment is preferred at the start of each session. It is recommended that checks be made out prior to the start of the session so that our valuable time together is not taken up with payment arrangements.

3. Statements, insurance forms, paid receipts, etc. are prepared monthly. I am happy to assist you in obtaining reimbursement from your insurance company However, the responsibility for timely payment rests with you, regardless of the insurance reimbursement schedule. If any claims for payment are denied by your insurance company, you will be responsible for paying those claims.

I agree to pay the psychotherapy fee/co-payment of $___________per session. I have read the above Practice Policy Statement and agree to abide by the terms.

_________________________________ _________________________________

Patient Date

_________________________________ _________________________________

Sharon Drexler, PsyD. LCSW Date