CEDAR RIDGE COUNSELING CENTERS

PO BOX 1229
Sykesville, MD 21784
PH 410-552-0773   FAX 410-549-3197

ELDERSBURG   OWINGS MILLS   WESTMINSTER

POLICIES FOR CLIENTS

Please read the information below and feel free to ask any questions. You have the right to ask or as much information as you would like in order to make an intelligent decision about the services you desire.

1. **APPOINTMENTS:** Standard appointment time is 45 minutes for a psychotherapy session and if you would like more time, please discuss this with your therapist. If you are late for the session, that time will be lost from the session. Your therapist will make every effort to be available at the scheduled time.
2. **FAILED APPOINTMENTS:** The time that has been reserved for you is your time. Appointments not cancelled 24 hours in advance will be subject to a cancellation fee. You, not your insurance company, will be billed a fee of $60 for appointments missed with an LCSW or LCPC and $85 for appointments missed with a Ph.D or PysD.
3. **BILLING:** Clients are responsible for obtaining accurate information from insurance carriers as to deductibles, co-payments, and pre-certification. Any errors in information received, resulting in a balance owed to provider, will be the responsibility of the client to pay. Clients are also responsible for becoming aware of any changes in their coverage and notifying their therapist. Co-payments are due when services are rendered. Clients are ultimately responsible for fee payment, regardless of coverage. Your signature below authorizes your insurance company to pay Cedar Ridge directly for their share of the fees.
4. **TELEPHONE:** Telephone contacts between sessions should be limited to critical issues or appointment scheduling. If at all possible, telephone contacts should be limited to normal business hours (Monday – Friday, 8:30a.m. – 5:00p.m.). **Extended phone contact will result in a billed session.**
5. **MISCELLANEIOUS FEES: Returned checks** will result in a service charge of $25.00. A fee will be assessed at the usual hourly rate for letters, reports, forms, etc. requested by client.

Please check each statement and then sign below. I, undersigned,
__________ agree to the policies described above
__________ have reviewed the Statement of Limits of Confidentiality
__________ have read and agree with the patients Rights and Responsibilities.
__________ have read/received a copy of this Office's Notice of Privacy Practices.
__________ give consent for evaluation, psychotherapy, and /or psychological testing

Please Print Name (Responsible Party)   Patient Name

Signature   Date

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

FOR OFFICE USE ONLY

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)