**The Center for Psychological and Family Services**

Policies for MD visits

**Please initial by each section of the policies to indicate your understanding and agreement**

**Sessions and Fees:**

\_\_\_\_\_\_\_\_ Dr. Moore accepts some forms of insurance, but also provides fee-for-service care. At this time, Blue Cross Blue Shield and Aetna are the only plans accepted. For patients using health insurance, co-pays are due at the time of the visit. Patients may additionally be responsible for deductibles and non-covered services. If a patient is self-pay, Dr. Moore employs time-based billing.

* New patient (initial ) consultation: Adults (50 minutes) $250, Children (50 minutes, but likely to require a second session at the follow-up visit rate), $300
* Follow-up visits: 50 minutes $210, 25 minutes $130

**Cancellation and No Show Policy:**

\_\_\_\_\_\_\_ Keeping appointments is crucial to successful treatment. If you need to cancel an appointment, please do so as soon as possible. If an appointment is cancelled more than 24 hours in advance, there is no penalty. If an appointment is cancelled less than 24 hours in advance, it is considered a “No Show”. This represents a loss of Dr. Moore’s time, and a loss of the opportunity for another patient to receive care. One No Show may occur without penalty per calendar year. The fee for additional No Shows is $50 for a 25 minute appointment, and $100 for a 50 minute appointment. This is not reimbursable by insurance. Excessive numbers of cancellations and No Shows may be grounds for termination and transfer of care to another provider

**Communication Outside Appointments:**

\_\_\_\_\_\_\_ Dr. Moore may be reached through either the general clinic number or her direct line. Messages left for her will be answered within two business days. In the case of a psychiatric or medical emergency, call 911 or report to your nearest emergency room rather than leaving a voicemail. There is no charge for phone calls which last less than ten minutes. Phone calls lasting longer than this will be billed in ten minute increments, at a prorated charge for the professional time involved at the usual and customary rate. This is not covered by insurance. To protect your privacy, Dr. Moore does not use email, texting, or other digital forms of communication to speak with patients.

\_\_\_\_\_\_\_ Any reports or professional consultations requiring time beyond that of the regularly scheduled session will be billed in ten minute increments at a pro-rated charge for the time involved, at the usual and customary rate. This is not covered by insurance.

**Refills:**

\_\_\_\_\_\_\_ At the time of a visit, enough medication refills will be provided to last until the next scheduled visit except if limited by law. If an appointment is cancelled or moved, you may run out of medication before the next available appointment. Dr. Moore is willing to provide one additional refill between appointments if needed. Due to the need for medication monitoring and patient safety concerns, an in-person appointment will be required for any further refills.

**Confidentiality:**

\_\_\_\_\_\_\_ The information discussed with Dr. Moore is considered private and confidential. This means that it will not be disclosed to other individuals or entities except in a few specific circumstances. The most pressing circumstance is when someone discloses information that suggests there is risk to the safety of themselves or other people. In this case, Dr. Moore may act as needed to prevent anyone from coming to harm. Other circumstances include, but are not limited to:

* When you authorize Dr. Moore to share information
* When sharing information is needed for the provision of your healthcare, such as with other staff at the Center for Psychological and Family Services or with another physician who will be covering Dr. Moore during an absence
* To insurance providers to obtain payment for services
* If required by law

**Parents of minors:**

\_\_\_\_\_\_\_ For the safety of both patients and staff, **Dr. Moore does not see pediatric patients who are unvaccinated.** By initialing above you acknowledge that your child is up to date on all vaccinations.

\_\_\_\_\_\_\_ It is understood that confidentiality between Dr. Moore and your child or adolescent is an essential part of the therapeutic process. This means that, while you may give information freely to Dr. Moore, she will hold in confidence information which is given to her by the child or adolescent, to the degree appropriate given the patient’s needs and developmental stage. As above, Dr. Moore may freely disclose information related to safety concerns. It is understood that Dr. Moore exercises her judgement and clinical experience in determining what is a safety concern and what is not, and that, while it is possible a parent may disagree with Dr. Moore’s assessment, ultimately she must decide what is appropriate to disclose.

**Custody, Litigation, and Legal Concerns:**

\_\_\_\_\_\_\_ In the case of minors with two parents who both have legal decision-making powers, Dr. Moore requires the consent of both parents, regardless of marital status, to enter into a treatment relationship with the family. If a court has granted legal decision-making powers exclusively to one parent or a guardian, that paperwork must be presented at the first appointment.

\_\_\_\_\_\_\_ Dr. Moore is not trained in forensic or custody evaluations and will offer no comment on this aspect of cases. Dr. Moore does not make court appearances. Such an appearance represents a significant loss in terms of time and opportunities for other patients to receive care. Nevertheless, if required to appear in court, Dr. Moore’s rate for such an event is $500 an hour, not reimbursable by insurance, and includes time spent in preparation, transit, legal proceedings, and other activities which required her participation.

**Summary Statements:**

All of the above policies and procedures may be subject to change or modification by Dr. Moore as she sees fit. You will be notified of any such changes as they apply to your care or that of your child.

**Please read and sign the following:**

I have read, understand, and agree to comply fully with the above policies. I recognize and

accept full financial responsibility for all professional services rendered.

Signature of Patient/ Responsible Party #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AND (if applicable)

Signature of Responsible Party #2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_