

LINDA BERLIN, PSY.D. & PSYCHOLOGICAL ASSOCIATES, P.A

CLINICAL PSYCHOLOGY
GENERAL PSYCHIATRY
CHILD AND ADOLESCENT PSYCHIATRY

1890 N. University Dr. Suite 215
Coral Springs, FL 33071
(954) 227-2700

7000 West Palmetto Park Rd. Suite 407
Boca Raton, FL 33407
(561) 347-0997

psychologicalassoc.com

Policy and Procedures for Psychological Services

Welcome to Linda Berlin, Psy.D., and Psychological Associates, where we are dedicated to providing you with the highest quality of care within a trusting and comfortable therapeutic relationship. The following policies and procedures are devised in the interest of maintaining a mutually respectful therapeutic relationship as well as clear expectations regarding your treatment. Please read each section thoroughly and initial where requested, indicating your agreement to the following. Please keep the copy provided to you for future reference. You are invited to discuss any questions or concerns with your doctor / therapist.

Appointments

Typically, psychotherapy is scheduled as one or more **45 minute** sessions per week. The frequency of therapy will be agreed upon in advance to adequately meet your needs and treatment goals. If you believe that this session length is insufficient, please discuss your options with your doctor / therapist. As a courtesy to other patients and in the interests of running on time, you cannot be given more than 45 minutes of time unless previously arranged. **Please arrive on or before the time your session is scheduled. If you arrive late, you will only be allotted the remaining time of your session.** On occasion, your doctor / therapist may be delayed in beginning your session on time. Please be assured that you will still receive your full 45 minutes if this occurs.

Your doctor / therapist will make all appointments with you directly. To make, cancel, or reschedule an appointment, please leave a detailed message for your doctor / therapist including the times you are available for an appointment. The office does not make routine confirmation calls but will make its best effort to confirm your appointment at your request only. **If you do not receive a confirmation call, you are still responsible for attending your session at the scheduled time.**

Your appointment time is exclusively reserved for you. As a courtesy to your doctor / therapist as well as other patients who may be awaiting an appointment, please call as soon as possible to advise if you need to cancel. After hours, you may leave a message on your doctor / therapist's voice mail. Please be aware that **you will be charged in full for all sessions cancelled without 24 hours notice or for any appointment for which you do not show. For Saturday appointments, a 48 hour notice is required for cancellation without charge.** Your insurance will not be billed for late cancellations or no shows. If you miss two consecutive appointments without appropriate notice, your standing appointment time will be given to another patient.

Office Hours and Phone Call Policy

Your doctor / therapist's office hours are as follows: _____
_____. Between the hours of 9:00 and 5:00 pm Monday through Friday, all phone calls can be answered by the administrative staff by following the appropriate voice prompts. If you would like to leave a message for your doctor / therapist and/or need a return call, please leave a message directly in his/her voicemail by following the prompts. **Messages are typically retrieved at intervals throughout the day but are usually returned at the end of each business day, unless your doctor / therapist has a break in the schedule to return the call sooner.** All calls during office hours are returned within 24 hours. All non-emergency messages left during your doctor / therapist's days off, including weekends will be answered within 48 hours. Please be sure to leave all numbers at which you can be reached and the times you are available to take a return call. If you miss your doctor / therapist's call, you may return the call to the office number only. If you return the call to your doctor / therapist's cell phone, it will likely go unanswered. Messages left on your doctor / therapist's cell phone or home phone will not be responded to. Please direct any administrative questions (i.e. billing, insurance questions, authorizations) to the front office staff. If your doctor / therapist will be unavailable for any length of time, you will be informed in advance and a colleague will provide coverage for urgent phone calls and related matters.

If your call is urgent, you may page your doctor / therapist for emergencies only by following the prompts provided by the voice mail service. Every effort is made to respond to all emergency pages within one hour. Please be aware that there may be a delay in responding to emergency pages occurring between the hours of 11:00pm and 7:00am, simply because your doctor / therapist may not hear the page while sleeping. **If your situation requires more immediate assistance or is life threatening, please call 911 or contact the First Call for Help Crisis Line at 954-537-0211 before paging your doctor / therapist.**

Please ensure you leave all numbers at which you can be reached in order to receive a return call. Calls cannot be returned to a pager. In the rare circumstance that you do not receive a call back within a reasonable time, please assume an error in the system prevented your doctor / therapist from being paged and call back.

Financial Policy

My fee for evaluation and psychotherapy is discussed during the initial phone conversation. Fees for psychological testing will be determined after a full clinical assessment to help determine which particular tests are indicated. Other related services such as report writing, attendance at meetings, authorized consultations, preparation of records or treatment summaries, or other services you may request are billed at a rate of \$200.00 per hour. **All payments for services are due in full at the time services are rendered, even if you come late or decide to leave early.** Partial payments are unacceptable unless previously arranged with your doctor / therapist. Non-payment of fees could result in having to discontinue services until the balance is paid.

Your insurance, if applicable, will be billed as a courtesy to you. Please be aware that **it is your primary responsibility, not that of the office, that your insurance company pays your claims accurately and timely.** You are encouraged to consult directly with your insurance company to ensure appropriate payment, if applicable.

The office will call your insurance to verify your benefits and will pass that information along to you. The office staff cannot guarantee that the benefits quoted on the phone are accurate. Please be aware that you are ultimately responsible for being knowledgeable about your benefits, including deductible information, maximum payments and sessions allowed, and the need for authorizations. You are encouraged to confirm your benefits directly with your insurance company and clarify any discrepancies. Your payment due to the office will be a direct reflection of patient's financial responsibility as indicated on the EOB (Eligibility of Benefits form) for a given date of service.

If full payment is not received from your insurance company within 60 days of filing, you will be billed and held financially responsible for all such charges in full. It is then your responsibility to get reimbursed from your insurance company. The office may assist you if you need to file a claim but the office is not responsible for whether your insurance company sends reimbursement. Any balances remaining over 60 days of the date you are billed will be referred to a collection agency, at which time a 30% surcharge will be added to cover costs of collection. If you are having difficulty making payment in full, please speak with the office staff regarding an appropriate payment plan to avoid collection agency efforts. **To avoid increasing your financial burden, any individual having difficulty paying for services will be referred to an appropriate community mental health facility for reduced cost care.**

The individual (whether parent, grandparent, or guardian) who initiates psychological services for a child is financially responsible for all payments, even if they are not the insurance policyholder or if another is legally designated to pay for services. If another party is responsible for payment, it is your responsibility to collect payment from them in advance or to request they reimburse you directly. If you prefer, they may leave a credit card on file at the office or send payments in advance. However, the office will not bill another individual even if they are deemed legally responsible for payment. If you designate another individual to bring you child in for treatment, that party must bring your payment with them to the session.

Consultation Calls

You are encouraged to discuss any issues and concerns at the time of your appointment and if necessary, request a second appointment at your doctor / therapist's earliest availability if there are matters that cannot wait until your next scheduled visit. In order to ensure that your doctor / therapist can dedicate the appropriate time to your concerns, therapeutic issues and guidance can only be provided within the parameters of your session and not by phone calls outside of your session. You always have the option of arranging a phone session or consultation call if you feel it is necessary between therapy appointments. **With the exception of necessary and occasional phone calls that only require a few minutes time, all calls for consultation with your doctor / therapist will be billed at a prorated rate in 15 minute increments based on your agreed upon session fee .** These consultation calls cannot be billed to your insurance

company. In addition, requests for consultation with other individuals such as attorneys, other parents, and teachers will also be billed in this manner. Any requests for written reports, letters, or the completion of documents that take 15 minutes of time or more (excluding requests for insurance authorization), will also be billed at the prorated fee in fifteen minute increments. Your insurance company does not cover such services. Payment for these services is expected at the time of your next session.

Legal Issues

Please make your doctor / therapist aware if there may be legal involvement at any time during or following your treatment and to what extent information may be requested by other parties. Your treatment will remain absolutely confidential unless you designate by a specific release of information that disclosure is necessary or there is a court order from a judge demanding its release. You are encouraged to discuss very specifically the kind of information to be released and withheld in these circumstances, although it is important to realize that limitations to confidentiality apply as indicated separately. **A separate fee schedule applies for any legal correspondence (written or verbal), consultation, deposition, or court appearance.** Please request this fee schedule in advance so you are aware of the costs to you.

A Note for Parents

Your child's individual therapy time is reserved for him or her almost exclusively. Periodic consultations with parents for feedback or to address concerns with your doctor / therapist are arranged separately and without your child present (with the exception of family therapy). If you have information to pass along to your doctor / therapist prior to your child's session, you are encouraged to write a note, fax a note, or leave a voice mail for your doctor / therapist to review prior to the session. **Be assured that if any critical information emerges from your child's session, I will always share it with you in writing or by phone by the end of that day.**

If your child is going to be brought to a session by someone else, or if they are old enough to come on their own (16 years or older), please make sure you send payment for the session with them or in advance. For your convenience, you may leave a credit card on file at the office to be billed at the time of session.

When you bring your child for therapy, you are required to wait for them in the waiting room. Please do not plan to run errands while your child is in therapy. There may be times when it is necessary to call a parent into the session or if your child needs you for any reason. Your doctor / therapist and the office staff cannot supervise your child if you leave the office. Children under 16 cannot wait alone in the waiting room or be left in the hallway while your doctor / therapist consults with a parent.

If you are separated or divorced, please be aware that you must notify your child's other parent and have their consent for your child to participate in therapy. **No child can be seen without consent from both parents in accordance with the laws of parental responsibility and parental rights.** You will be asked to certify that you have informed and have obtained consent from the other parent. In most cases, both parents will be directly invited to the initial session and will be expected to be involved in the treatment process. Any concerns about this need to be

addressed with your doctor / therapist directly. All parents, even non-custodial parents, have a right to information regarding their child's diagnosis and treatment.

Although you, as a parent, have the right to information regarding your child, your doctor / therapist will uphold a degree of confidentiality regarding the specifics of what your child discusses in session. This is necessary to preserve the trust of the therapeutic relationship and ensure effective therapy. In no way will critical information be withheld and any disclosure made by your child that indicates there may be risk to themselves or others will be immediately communicated to you.

Acknowledgement of Policy and Procedures

By signing below and initializing each section as indicated, you are agreeing that you have read this policy and will maintain a copy for your records. By signing below, you are also acknowledging that you have had the opportunity to discuss any concerns with your doctor / therapist and have had your questions adequately answered. Your signature commits you to upholding all the agreements detailed herein.

Name of Doctor / Therapist Providing Psychological Service

Print Name of Patient

Date

Signature of Patient

Print Name of Parent/Guardian, if participant is minor

Signature of Parent/Guardian, if participant is minor

Doctor / therapist's Name

Signature