

BARRY ERDMAN, LCSW, DCSW
Adult, Couple and Family Psychotherapy
1900 Folsom St Ste 203 • Boulder CO 80302-5723
be@BoulderTherapist.com • www.BoulderTherapist.com
303 444-1404 • Fax: 303 444-3491

NEW CLIENT PSYCHOTHERAPY POLICY

The following information is intended to clarify our arrangement for working together. Please read, sign, date and return it to me by our second session. If you have any questions, Please feel free to ask me about them when we next meet. I'll also give you a copy to keep.

Beginning Therapy; The Initial Interview: It is important to choose a therapist who you trust, listens, understands, and can offer you the kind of help you're seeking. For this reason, you are invited to interview me and ask any questions you may have to help you determine if we have a good match for working together, including my clinical training, credentials, professional experience, therapeutic orientation, methods and techniques. I'll also be interested to hear more about your concerns and what has led you to seek professional help. In addition, we can discuss how to best set appropriate goals for working together, including the expected duration of the counseling to best meet your goals. There's no payment obligation to meet with me for the first interview hour. However, if you determine that you'd like to continue working with me during or after that session, the initial session will then be billed.

Fees/Payment Options: \$125.00/hour for individual, couples or family therapy. Cash, check or credit card payments are accepted in office and due in full at the time of your scheduled appointment. Online payments in advance can be made using Paypal. A link to Paypal is provided on my web site. Therapeutic phone calls longer than ten minutes, extended consultations and other auxiliary services requested will be prorated accordingly. Additional traveling fees may be charged for out of office visits. A late payment fee of 2% interest compounded monthly will be added to balances remaining unpaid after 30 days. You are responsible for any additional returned bank check or credit card fees. Collection procedures may be initiated after a 60-day period where no attempt or agreement is made to pay off balance otherwise. Any exceptions to the policy above must be discussed and agreed to beforehand.

Cancellations/Missed Appointments: 24-hour notice is required to cancel or reschedule appointments without penalty. Exceptions made only for emergency circumstances (ex.: hazardous weather driving conditions, severe or contagious illness, etc.). ***Missed appointments are charged at the full session rate. Appointments cancelled or rescheduled within 24 hours are billed at \$75.00.***

Billing/Insurance: ***You are responsible for payment in full, regardless of your insurance coverage or claim status.*** A submittable billing statement can be made available to you and will contain all pertinent information required by your insurance company for reimbursement. In most instances, you will be able to file your own insurance claim by attaching and mailing my statement with your insurance claim form. I will submit claims for you if required. Co-payment only terms will be considered only after insurance

claims benefits have been verified. You are responsible for verifying your insurance coverage, my provider network status, or requesting pre-authorization to ensure receiving benefits. Please note that your diagnosis or treatment may not necessarily be covered by your insurance plan. Some plans require special attention and handling. Please check with me if you have questions. I'll do my best to assist you, whenever possible.

Communication: My confidential office phone voice mail will take your message if I am with another client or otherwise unavailable. I generally check messages throughout the day, in the evening and during the weekends, however, I may not be able to return your call immediately. ***I do not provide on-call 24 hour crisis intervention.*** Phone sessions or audio/video conferencing online via the Internet may be conducted, if discussed and agreed upon in advance. When I am out of town or otherwise unavailable for extended periods, my office phone message will direct you to a colleague providing clinical consultation backup if needed during my absence. You may send e-mail to me for brief communication exchanges or rescheduling inquiries. However, ***communicating by e-mail is never secure and may breach confidentiality mandates.*** I attempt to read e-mails on a daily basis, but will respond to phone messages more reliably. Please leave a phone message and do not email to cancel to reschedule appointments.

Termination of Therapy: You can elect to discontinue therapy at any time. If you decide to change our plan for meeting, please discuss this with me before quitting. I also reserve the right to discontinue meeting with you if you do not keep agreements with me, including your financial responsibilities.

Modifications:

I have read, understand and agree to the above psychotherapy policy information. I also understand that I could be responsible for additional expenses including collection, court or attorney's fees if I do not follow the terms of this contract. I also give permission to release and provide to my insurance carrier any information necessary for billing and claims processing purposes.

Print Client's Name

Client's or Responsible Party's Signature

Date

If signed by Responsible Party, please state relationship to client and authority to consent:
