

# SCOTTSDALE PSYCHOLOGICAL ASSOCIATES

11000 North Scottsdale Road, #163  
Scottsdale, Arizona 85254

## OFFICE POLICIES/CONDITIONS OF TREATMENT

Scottsdale Psychological Associates (SPA) provides treatment services with respect for dignity and rights of the individuals and families seen.

I hereby authorize SPA to conduct an evaluation and perform treatment for myself and/or my dependents with regard to psychiatric or behavioral health problems.

My signature below indicates that I have read and understood the following office policies and conditions of care.

**RELEASE OF INFORMATION:** All client contacts and records shall be treated in a confidential manner. In the interest of quality of care, however, SPA may disclose all or any part of the patients' medical, psychological, and/or financial records to the following third parties as necessary:

1. Any party associated with payment of all or part of the patient's financial obligation including insurance companies, workers' compensation payors, governmental agencies, billing service personnel, or electronic billing intermediaries;
2. Any professional member of SPA including psychiatrists, psychologists, social workers and/or therapists at the discretion of the treating clinician;
3. Primary care physicians and other health care professionals in order to provide continuity of care.

**Initials:** \_\_\_\_\_ **Do you give us permission to contact your PCP?**  Yes  No

**FINANCIAL AGREEMENT.** If indicated, SPA will bill your insurance or Medicare as a courtesy to you. At or prior to the first appointment, the responsible party agrees to provide all insurance information. The responsible party also agrees to notify the office of changes in coverage within 10 days and is responsible for all charges not covered by insurance as allowed by third party payor agreements. Non-physician providers accept Medicare assignment. Any fees incurred in the collection of this account becomes the responsibility of the patient/guardian. Such fees may range up to 30% of the amount owed. **If your account is sent to collections, no further services will be provided until that balance is paid in full.**

**CALLER ID:** Please be aware that "Scottsdale Psych" will appear on your caller ID whenever we phone the number you provided.

**Initials:** \_\_\_\_\_ **COPAYMENTS ARE DUE AT THE TIME OF SERVICE. ANY CHECK WHICH IS RECEIVED BACK FROM THE BANK IS SUBJECT TO A \$35.00 PROCESSING FEE.**

**Initials:** \_\_\_\_\_ **ADDITIONAL CHARGES:** Extended phone calls, written reports and correspondence will be subject to an additional charge.

**Initials:** \_\_\_\_\_ **NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received a copy of the Notice of Privacy Practices.

**Initials:** \_\_\_\_\_ **APPOINTMENTS:** Please contact the office at least 1 business day in advance to cancel an appointment. Insurance does not cover missed appointments and late cancellations. Therefore, the responsible party will be billed for missed appointments and late cancellations as follows: (this is 50% of our billable rate)  
MD/DO \$60.00 PSYNP \$ 45.00 PHD \$75.00 LPC \$65.00

**Initials:** \_\_\_\_\_ Providers in our practice limit our services to treatment and not forensic/legal work, which requires different training, ethics and focus. Therefore we will not write letters, consult with your attorneys or release records in any legal dispute.

**EMERGENCIES:** After hours emergency calls will be answered by our answering service and your therapist will be paged. In life-threatening situations, please call 911.

\_\_\_\_\_  
SIGNATURE PATIENT/PARENT OF MINOR

\_\_\_\_\_  
DATE

Modified May 2011