

# 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.

**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.

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

**COPAYMENTS ARE DUE AT THE TIME OF SERVICE. ANY CHECK WHICH IS RECEIVED BACK FROM THE BANK IS SUBJECT TO A \$25.00 PROCESSING FEE OR THE BANK FEE, WHICHEVER IS LARGER.** \_\_\_\_\_(Please initial)

**ADDITIONAL CHARGES:** Phone calls, written reports, court reports, correspondence and legal work may be subject to an additional charge. \_\_\_\_\_(Please initial)

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

**APPOINTMENTS:** Please contact the office at least 24 business hours in advance to cancel an appointment. Insurance does not cover missed appointments and late cancellations. Therefore, the responsible party will be billed for 50% of the appointment charge. \_\_\_\_\_(Please initial)

**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 July 2006