PATIENT INFORMATION SHEET

Before your initial visit please complete the Client Intake form, this Patient Information form, and read and sign acknowledgement of the HIPPA regulations form. Please mail or bring these forms with you on your initial visit.

APPOINTMENTS

Appointments will be scheduled at a time acceptable to both the patient and the therapist and last 50 minutes. Typically, clients are seen once a week.

FEES

Federal Truth in Lending Disclosure Statement for Professional Services

Part One - Fees for Professional Services

I (we) agree to pay Debra Alper, LCSW of Life Transitions Counseling, LLC, a rate of **$ 160** per clinical unit (defined as 50 minutes session) for counseling. Payment is due at the time of the session by cash or check.

Part Two - Cancelation Policy

There is a 24 hours' notice cancelation policy. If you cancel a scheduled appointment with less than 24-hour notice, you will be charged a $160 cancelation fee. Our scheduled time is reserved exclusively for you, and if cancelled with less than a 24-hour notice, the time is lost. As all of us have unexpected situations and emergencies that come up in life, so it is important that I enforce this policy, regardless of exception, for all my clients.

Part Three - Clients using Medical Insurance

If insurance is being used for reimbursement of the session costs, it is the client's responsibility to contact the insurance company. I am an out of network provider. I will provide you with a monthly statement that contains all the relevant information about the session, dates of service, charge and amount paid and your diagnosis and treatment codes. You will then be able to submit the statement to your insurance company for reimbursement directly to you.

I HEREBY CERTIFY that I have read and agree to the conditions and have read the Federal Truth in Lending Disclosure Statement for Professional Services.

I HAVE READ THIS PATIENT INFORMATION SHEET AND UNDERSTAND THE REQUIREMENTS AND RULES OF THIS OFFICE. I AGREE TO THE TERMS THEREIN AND GIVE MY CONSENT TO THE EVALUATION / TREATMENT PROCESS WITH Debra Alper, LCSW

Person responsible for account: _____ **Date:** _____/_____/_____