Antone F. Feo, Ph.D. & Associates, Inc.
OFFICE PROCEDURES

(440) 899-1300 (phone) www.afeophd.com **(440) 899-0266 (fax)**

Thank you for choosing Antone F. Feo, Ph.D. & Associates, Inc. We are dedicated to assisting you with your concerns and promoting your personal growth. To assist in this process the following information is listed for your reference.

1. The office is open Monday through Friday, 8:00 a.m. to 9 p.m., and Saturday 8 a.m. to 4 p.m. We are closed Sundays.

2. The initial interview is charged at $200 a professional hour (60 minutes). Individual psychotherapy sessions are $180 a professional hour (60 minutes) and family sessions are $130 a professional hour.

3. ***We require your payment at the time of service*** and accept check, cash, VISA, MasterCard, Discover, and American Express for payments; however, there is a $10 minimum when charging. There is a $30 fee for all returned checks.

4. We complete and file all insurance claims for primary insurance. ***While we extend this service as a courtesy, you are ultimately responsible for the account.*** **In the event of specific custody regarding minor children, the individual signing this Office Procedure is ultimately responsible for the account.** In the case of blended families, custody paperwork *must* be brought in at the initial visit.

5. If you need to contact the practice after hours call 440.899.1300 to leave a message, including your phone number. In the case of an ***emergency***, go to the nearest emergency room or leave a message on the voice mail at 440.864.4798. We will return calls at the earliest possible time.

6. We require 24 hours notice if you must cancel or reschedule an appointment. Cancellations that **occur less than 24 hours of the appointment time may be charged a $50 Late Cancel Fee. If an appointment is missed without the courtesy of a phone call, we charge $100 for the No Show Fee. These charges are not covered by insurance and will need to be paid prior to your next appointment.** If an appointment can be rescheduled within the week of the missed appointment, the fee may be waived.

7. Payment in full is required before ***any*** psychological report will be sent out from this office. Also, there is a fee for letters written, correspondence sent, and/or copying of files based on the work involved and at the discretion of the counselor. All fees must be paid in advance.

8. It is the responsibility of the client, or the client's parent/guardian, to keep the office updated with correct insurance information. Failure to do so could result in the client, or client's parent/guardian, being totally financially responsible for all services provided.

9. In most cases there are no fees when utilizing **EAP (Employee Assistance Program)** benefits.

STATEMENT OF CONFIDENTIALITY

Any and all information and/or records that we have about you are kept in strictest confidence. Your confidentiality is protected by law and by standards of good practice. Under normal circumstances, we can release information about you only if you have completed, signed and dated authorization documents. Law and standards of good practice allow us to disclose information without your authorization under the following circumstances:

- You are a risk to yourself or other(s).
- We suspect child/elder abuse or neglect.
- Medical personnel request information during a medical emergency.

- Disclosure is required under court order.
- You commit a crime against a staff member or property of our practice.

POSSIBLE RISKS OF TREATMENT

As a consumer of psychotherapy you may experience some level of anxiety, depression, somatic concern, or other discomfort. If any of these symptoms present themselves, please discuss them with your therapist.

TREATMENT OF ADULTS UNABLE TO EXERCISE RATIONAL JUDGMENT OR GIVE INFORMED CONSENT

Since this is an outpatient, private practice facility without case management resources, it would be unusual for an individual who is unable to exercise rational judgment or give informed consent to be seen. If such occasion should arise, the clinician would first attempt to contact the individual's emergency contact person after obtaining a release of information. If unable to accomplish this, the appropriate emergency resources would be contacted – mental health emergency or 911.

If an established client presents with a life-threatening emergency, the clinician will call 911 and stay with the client until the emergency is resolved.

TREATMENT OF MINORS

Minor children are not seen at this facility without the written consent of their parent or guardian. When an appointment is scheduled it is determined that a parent/guardian must accompany the child/adolescent for the first visit to give written consent. **In the event of specific custody regarding minors, the individual signing this Office Procedure is ultimately responsible for the account.** In the case of blended families, custody paperwork ***must*** be brought in at the initial visit. Clinicians actively encourage ongoing involvement of parents or guardians in the treatment of minor children and adolescents. ***Children should not be left unattended in the waiting room*.**

INDEPENDENT CONTRACTORS

There are several independent contractors working at the site of AFF. As an independent contractor, she/he is not associated or affiliated with AFF. If AFF refers patients to an independent contractor within this office or another professional outside this office, AFF is not responsible for the professional services that are provided.

AUTHORIZATION TO FILE INSURANCE/FINANCIAL RESPONSIBILITY STATEMENT

I hereby authorize said assignee to release only information necessary to secure the insurance payment. I hereby assign all medical benefits, including any major medical benefits to which I am entitled including Medicare, private insurance, and any other health plans to: Antone F. Feo, Ph.D. and Associates, Inc. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance.

I have read and understand all the above information.

Signature _____ Date _____

Circle if Parent or Guardian of minor child

_____

Please print name