Maria T. Aranda, Ph.D.

Licensed Psychologist #PY5983

Scheduling and Billing Policies
New Patients
Effective January 2012

This form serves to outline my general office policies. **Please read it carefully as it contains important information.** I will provide you with a copy to retain for future reference.

SCHEDULING: Psychotherapy services are provided on a regular schedule, weekly in most cases, unless therapeutic needs dictate a more or less frequent schedule. I request as much advance notice as possible in order to fill your appointment if you are unable to make it. **You are responsible for the fee for the session if less than 48 hours notice is given.** You can leave a message on my voicemail (813) 431-2798 at any time, 24 hours a day**. I reserve the right to terminate services after two missed appointments (less than 24-hour notice).**

CONFIDENTIALITY: Psychological services are confidential as provided by Federal and Florida laws. I comply with all regulations regarding the privacy of psychological information and comply with the HIPAA law. I will provide you with a separate form regarding privacy policies as required by HIPAA.

WORKING WITH MINORS: Treatment of minors is a collaborative process and open lines of communication with parents and guardians help move the pace of treatment along. In the case of divorce or separation, it is also important that all individuals who have custody provide consent for treatment in writing. Treatment or evaluation cannot commence without said consent.

CLINICAL EMERGENCIES: **My practice does not include a back-up answering service.** If you or I believe that your mental health needs requires this type of service, I reserve the right to transfer you to a practice or agency with such said services. I check my messages regularly Monday through Friday between 8 AM and 5PM. I make all efforts to respond to crises and emergencies as promptly as possible. **If an emergency is life-threatening and requires immediate attention that I am unable to provide, assistance can be sought from the nearest hospital emergency room or by calling 9-1-1.** The Crisis Center can also be reached at 2-1-1. After-hours non-emergency phone calls will be returned during regular office hours.

FEES AND BILLING/INSURANCE: I currently am on the provider list for Tricare insurance plans. I do not use any business associates and perform all billing myself. Although your insurance carrier may pay for claims on your behalf, **all unpaid claims are the member's responsibility**. All co-pays are required at the time of service. When providing information to your insurance, I will only give the required information so as to protect your privacy.

If you decide to not utilize your insurance for payment, the fee for individual psychotherapy is $175 for an initial consultation and $150 for subsequent sessions. Sessions are 50 minutes long. I do expect payment for each session to be made at the time of the appointment. **Checks should be made out to "Maria T. Aranda, Ph.D., LLC"** for the amount shown on the bill. If a large unpaid bill is accrued (more than 2 sessions), I may decide to discontinue treatment until the balance is paid or payment arrangements have been made, as is clinically appropriate. In addition, during instances where a client is refusing to pay for services already rendered, I may involve the use of collection agencies if payment arrangements cannot be agreed upon. I provide complimentary telephone consultations that are 15 minutes or less. If such telephone consultation is longer than 15 minutes, my hourly rate will apply on a prorated basis. Letters are also subject to prorated hourly rates.

CHILDREN UNDER 14: Please remember that I am unable to supervise children in the waiting room once their session is over. For their safety, please come into the waiting room to pick them up (rather than having them wait outside for your car), making sure that you are back at least 10 minutes before the end of the session. This will also provide the opportunity for me to check in with you if an urgent matter came up during the session.

INCLEMENT WEATHER: In case of inclement weather, I try to come into the office if at all possible. I will call to notify you if my office is closed. Alternately, you can call my office at 813.431.2798. My outgoing voicemail messages will notify if my office is closed. I do not necessarily close if the public schools or local governments are closed.

FORMS OF COMMUNICATION: You are welcome to contact me via email at MariaAranda@tampabay.rr.com. This is a good way to provide me with information outside of a session, such as a specific event that occurred during a week or an update on a child's behavior. **IMPORTANT – Please note that e-mail communication is not a secure means of communication, as others may inadvertently have access to e-mail information**. Email is for non-emergency communications. Although you have the right to send me e-mails with sensitive information, I will not send e-mails with sensitive and confidential information due to the non-secure nature of this mode of communication. Also, please note that I do not communicate via text messaging. Also messages can be delivered via phone messages to (813) 431-2798 or e-mail.

Agreement to pay for services

I, the client (or person acting for the client), request that Dr. Maria Aranda provide professional services to me or to _____, who is my _____.

I agree that I am responsible for the charges for services provided by this psychologist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account.

I understand that if my account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, Dr. Aranda has the option of using legal means to secure payment. I understand that this may involve hiring a collection agency or going through small claims court which will require Dr. Aranda to disclose otherwise confidential information. In most collection situations, the only information Dr. Aranda will release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. My signature on this form represents my agreement and consent to Dr. Aranda's financial policies.

_____

Signature of Client

_____

Printed name

I have read and understood the office and financial policies of Maria Aranda, Ph.D. and am in agreement. **My signature below also provides consent for treatment for myself, my child, or an individual for whom I am a legal guardian**. In cases of legal guardianship or custody, I attest that I have provided Dr. Aranda with accurate information about custody or guardianship and that I am able to consent to this treatment.

Name of person providing consent
(parent or guardian if under 18 years of age):_____

Signature of person providing consent:_____

Relationship to Patient:_____ Date:_____

Patient's name:_____

Patient's date of birth:_____

Home Address:_____

_____

Home Phone:_____Work Phone(s):_____

Cell Phones:_____

Emergency contact name and telephone number:_____

Person responsible for payment (**if different than above**):_____

Social Security number for person responsible for payment:_____

Billing Address:_____

_____

Home Phone:_____ Work Phone_____

Cell Phone:_____

Please note any restrictions on contacting you: (e.g., Do not leave messages at work phone)

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