

Office Policies

Please initial indicating that you have read and understand each item:

___ Confidentiality: I understand that Dr. Forrester’s staff will maintain confidentiality and will not provide any information about me or my child to others except under mandate of the law. (See consent form for details)

___ Cancellation: I understand that my failure to provide 24-hour advance notice of my cancellation will result in me being charged for the appointment. I understand all missed appointment fees must be paid prior to (or on the date of) the next scheduled appointment.

___ Missed Group Sessions: I understand that I am allowed one missed session per semester in group therapy. Even with 24-hour notice, all missed group sessions (aside from one missed session per semester) are charged the full amount of the appointment fee and must be paid prior to (or on the date of) the next scheduled appointment. I understand that I will not be provided a receipt for missed sessions as this fee is not reimbursable by insurance.

___ Late Arrival: I understand that as a courtesy to other clients, I will not receive an extension of the scheduled appointment time as a result of my late arrival and thus my appointment will be shortened.

___ Identifying Information: I understand that any published research or other materials will not contain any identifying information and that my records will not be released without my written consent. Due to HIPPA, this also means that information will not be disclosed to anyone, even family members, without written consent.

___ Etiquette: I agree not to come into the office under the influence of alcohol or non-prescribed drugs. I agree to silence my cell phone and will not talk on my cell phone while in session unless there is an emergency. I agree to maintain privacy of others I may see in the office and will not disclose any information about other group members or their families (if participating in a group).

___ Payment: I understand that payment is expected in advance or at the time of service. Acceptable forms of payment are cash or check (credit cards are not accepted). Dr. Forrester does not accept insurance payment; however my receipt will contain the necessary documentation I need in order to file with my insurance company. I understand that I should have my payment ready prior to arrival to avoid any delay in services. A fee of \$25 will be applied for returned checks (and future cash payments required) and late payments.

___ Preparing for Initial Appointment: I understand that I need to prepare my child for their visit. There is no need to tell my child he/she is going to see the doctor. The word “Doctor” often triggers fears, especially in young children. Parents should tell their child they are going to see someone named “Ms. Michelle” who has a room full of toys that they can play with. Children are often excited to see the playroom and this helps allay any fears. I agree to assure my child that I will stay with them and they will not be left alone.

___ Preparing for Assessment/Evaluation: I understand that to prepare my child for an assessment/evaluation appointment I need to inform them that they will do “work” and will be provided with play and snack breaks. I understand that it is my responsibility to bring a snack to this appointment and that I will remain in the waiting room for the duration of the appointment.

___ Supervised Interns: I understand that services from Dr. Forrester’s supervised interns are considered an out-of-pocket expense and cannot be submitted to my insurance carrier for reimbursement.

Child’s Name

Child’s Date of Birth

Parent/Guardian Signature

Date