Teresa Bailey, Ph.D.
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Office Policies

About Fees and Payment

At this time I only accept checks and cash for payment.

_____Psychotherapy and Neurofeedback fees are to be paid at the conclusion of each session, unless other arrangements have been made between myself and the person(s) financially responsible for the treatment. Paperwork for insurance reimbursement will be provided upon request.

_____**For all Assessment/ Evaluations services, 100% of the estimated fees are due at the start of the assessment. Fees beyond original estimate are to be paid before the feedback session.** If the assessment requires less than the estimated time, any refund due the patient will be returned to the patient or patient's parent or legal representative at the end of the feedback session. **No report will be written until fees are paid in full, or payment arrangements have been made between myself and the person(s) financially responsible for the fee.** Fees more than 30 days overdue will be charged interest at the rate of 1.5% per month (APR =18%).

Your appointment is a time that is reserved exclusively for you. You will be charged for missed appointments unless prior arrangements have been made.
_____Psychotherapy and Neurofeedback patients will be charged for the full session fee.
_____Neuropsychological and assessment patients will be charged for the number of hours reserved for them on that particular day.

About Confidentiality

Any information which you disclose in the course of a consultation or therapy is confidential unless you provide written consent for the release of information, except for the following exceptions as provided by law: If a patient threatens injury or harm to himself or herself, to the person or property of another person, if a patient reports knowledge or reasonable suspicion of child or elder abuse, or if a person from the patient's family reports such information to me concerning the intentions or actions of the patient. If you have any questions or concerns, please ask for clarification.

About HIPAA Compliance

I am in solo private practice, and am my own HIPAA compliance officer. Please see "About Confidentiality" above. If you wish to view a more detailed statement of HIPAA practices of this office, please ask me to provide a copy of that document to you.

Psychotherapy process notes are protected by law, and may not be inspected. There is a separate file kept to note session attendance, fees paid and owed, diagnosis, etc., which may be used to provide information about you if you seek reimbursement from your insurer.

Neuropsychology and other assessments are an evaluation and consultation service. Neuropsychological and other assessment patients' rights to inspect their files vary, depending on the particular legal status of an individual situation, according to both state and federal laws. If you have any questions about this aspect of your assessment, please ask for clarification. Some insurance companies request copies of neuropsychological evaluations before deciding on benefits. If you release the report, I cannot be responsible for what use, current or future, may be made of it, as persons may review it who do not have the same obligations to confidentiality that I or your physician may have.

Unintentional Errors

If you find that there are factual errors in either billing or written reports, please notify me in writing about the error, and I will make needed corrections. If you dispute a diagnosis or finding, you may send by US Postal Service or other delivery service, signed, written comments that will be appended to your file. Email is not considered written notice. (**continues on other side**) -------->

About Insurance and HMOs

Payment for services is the responsibility of the patient or the named individual(s) responsible for the fee. I am not a member of any insurance panel or HMO. In this way I am able to provide services at a reasonable fee, protect your confidentiality from constant utilization review, and support your freedom to engage in appropriate assessment or therapy for your situation. If you request, an invoice of services provided will be issued for your records, and which you may submit to your insurer for reimbursement. Insurance reimbursement may be less than the total fee charged for services. Insurance may not be used for forensic evaluations, even if there is an underlying medical condition that is relevant to the forensic evaluation.

Insurance does not cover educational evaluations. If you have any questions regarding coverage, please direct them to your insurer. I can provide you with procedure and diagnosis codes, but this will not guarantee coverage, even if the referral has been made by your physician and your physician believes there is medical necessity for the evaluation..

Custody Questions

I do not provide civil Custody Evaluations, and will make no statements about civil custody matters. In situations where cognitive capacity to parent, or the treatment, parenting, and/or educational needs of a disabled or learning-disabled dependent are at issue, I will provide sub-contracted evaluations if an individual is referred by a custody evaluator or the court, but I do not make final recommendations about custody.

Additional Fees

Any time spent providing information, records, or interpretation of test data to any third party, by any means beyond the written neuropsychological report, will be billed to you at my standard hourly fee, and is generally not a covered fee by any insurer.

_____ Signature

_____ Print Name

_____ Date

_____Name of Patient, if a Minor

Research and Teaching Release

I conduct clinical research, teach, and supervise graduate students and licensed professionals. I would appreciate being able to use your or your child's clinical and test data in these activities. All personal identifying information will be removed before such information is used for research or teaching purposes. I do _____/ do not_____ give permission for my____/my child's _____ data to be used in research and teaching activities by Teresa Bailey, Ph.D., Ph.D. I understand that permission to use this data may be revoked, in writing, at any time.

_____Signature

_____ Print Name

_____ Date

_____ Name of Patient, if a Minor