Office Policies for Insurance & Private Pay Clients

Steve Daily, MS – Psychologist

119 NE 72nd Street – Gladstone, MO 64118

Phone: 816-420-8419

I look forward to working with you and would like to take this opportunity to supply you with a brief summary of my office practices.

FEES:

My initial diagnostic session is a one-time only charge of $135. My standard fee for counseling services (individual & family) is $110 per session and $50 for group. **I would ask that your co-payment be made at the time of each session.**

APPOINTMENTS:

Please try to schedule your return to appointments as soon as possible – preferably after each office visit so that you will be more likely to obtain the time that is most convenient for you.

CANCELLATION POLICY:

If you are unable to keep your appointment, please notify our office one working day (24 hours) in advance to avoid a fee. **If you do not keep your appointment or cancel less than 24 hours prior to the session, a standard missed appointment fee of $25 will be charged.** Payment will be expected at the time of your next session.

SESSIONS:

Sessions are typically 50 to 55 minutes in length. I try to conduct my sessions on time, so if you have been waiting for 10 minutes past your appointment time, please contact the receptionist to check.

EMERGENCY SERVICES:

Mr. Daily does not provide emergency services, and as a psychologist, does not have admitting privileges to a hospital. **If you are having a mental health crisis and feel the need to be admitted to a hospital, call 911 or go to any emergency room of a hospital for a mental health assessment.** There is a crisis line you may call at 1-888-279-8188.

PHONE CONTACT:

Mr. Daily will answer brief questions over the phone when is available at the office. More extensive questions are best to be asked at the next therapy session.

PATIENT SATISFACTION:

I want you to be pleased with the services you receive at Northland Behavioral Health & Wellness. If you are dissatisfied with any part of the services you receive or have suggestions as to how services can be improved, please communicate this to me.

I have read and understand the above policies.

_____ _____

Date **Signature of patient, parent, or guardian**

PATIENT REGISTRATION

Date _____ **Clinician Steve Daily, MS – Psychologist**

Name _____ Social Security #_____
Last First MI
Address_____ City_____ State_____ Zip_____

Day Phone _____ **Evening Phone _____**

DOB_____ **Sex: ____Male ____Female**

Marital Status ___Single ___Married ___Divorced **Name of Employer _____**

RESPONSIBLE PARTY

Name _____ Relationship to Patient_____
Last First MI
Address_____ City_____ State_____ Zip_____

Home Phone _____ **Business Phone _____**

Social Security # _____ **Employer _____**

INSURANCE INFORMATION

Primary Insurance Company

_____

Address (To Mail Claims)

_____

_____

Certificate # _____ Group #_____

Subscriber Name _____

DOB _____ SSN _____

Relationship to Patient _____

Employer _____

Secondary Insurance

_____

Address

_____

_____

Certificate # _____ Group #_____

Subscriber Name _____

DOB _____ SSN _____

Relationship to Patient _____

Employer _____

Consent for Treatment

The undersigned patient or responsible party (parent, legal guardian, or conservator) consents to and authorizes services by Steve Daily, MS, Psychologist. These services may include psychotherapy and other appropriate alternative therapies.

The undersigned understands that he/she has the right to:

1. Be informed of and to participate in the selection of treatment services.
2. Receive a copy of this consent upon request.
3. Withdraw this consent at any time.
4. Be referred to another professional if requested.

_____ _____ _____

Signature of patient **Signature of parent or legal guardian** **Date**

_____

Signature of witness

Client Confidentiality

Confidentiality is very important to the therapeutic process, and steps are taken to insure that your records be kept confidential. Please read the following guidelines so that you will understand when information can be released to another part.

Information which might be used to identify a client as a participant in therapy or information from the client's therapy record will not be released without the client's written consent, unless authorized or required by law.

Under certain circumstances, it may be required or authorized by law to release information without the client's consent. These include, but are not limited to:

- **Medical emergencies**
- **Court authorized releases**
- **Clients who represent a serious danger to self or others**
- **Child or elder abuse or neglect**

I have read and understand the above information.

_____ _____ _____

Patient, Parent, or Legal Guardian **Witness** **Date**

Steve Daily – Psychologist

Northland Behavioral Health & Wellness – 119 NE 72nd Street. – Gladstone, MO 64118
Phone: 816-420-3130 Fax: 816-420-8710

AUTHORIZATION

I authorize Mr. Steve Daily to release medical information which may be requested to process claims for payment of psychological services through an insurance carrier, prepaid medical plan, or government agency.

I request that payment be made to Mr. Steve Daily for any bills for service rendered to me by him.

I understand that I am financially responsible to him for any balance not covered by this authorization. I understand that I am responsible for co-pays and deductibles which I may owe. I realize that insurance filing is done as a courtesy for the patient and no responsibility is taken by Mr. Daily for denial or delay of payment.

_____

Responsible Party's Signature

NORTHLAND
Behavioral Health & Wellness

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT COVER SHEET

I, **_____,** hereby acknowledge that I have read and been offered a copy of the Notice of Privacy Practices as written by Northland Behavioral Health & Wellness. The effective date of this policy is October of 2020.

_____	**_____**
Signature of client / legal guardian	**Date**
_____	**_____**
Therapist's Signature	**Date**