Wellness & Relationship Counseling
Maureen DeLorenzo, LCSW

POLICIES & PROCEDURES

CLIENT AGREEMENT

I, ____________________________ hereby assume financial responsibility for all charges that may be incurred for treatment rendered to myself and/or my family. I understand that it is the policy of this office for the client to pay the therapist at the time of each office visit.

Insurance/ Payment for Services:
Fees are to be paid at the time the service is rendered. Payment may be check, cash, credit card. All returned checks will incur all associated fees. I understand that if my therapist agrees to accept assignment of insurance benefits, I am responsible for providing signed insurance claim forms and all necessary information for filing the claim for benefits with the insurance company. I am aware that I am responsible for any unpaid insurance claims or charges. If using private/self pay option, I will pay the agreed upon rate at the time of service and keep a credit card auth on file.

Cancellation Policy
Because time has been reserved exclusively for me and/or my family, I understand that I am required to provide at least twenty-four (24) hours advance notice if I am unable to keep the scheduled appointment. If I do not provide the twenty-four hours notice of cancellation, I am financially responsible for the reserved appointment.
The late cancellation fee is $50 for individual sessions and $75 for couple sessions.

Release of Information: I hereby give consent for the therapist to report back to the professional(s) who referred me for the purpose of informing them that I have come here for treatment and to occasionally let them know how I am progressing and that I am continuing and/or terminating treatment with you. This consent DOES NOT cover the release of information that I may disclose within my treatment sessions. An additional authorization form may be filled out to disclose such information.

Confidentiality
I acknowledge that I have received a copy and/or have been given an opportunity to read a copy of Maureen DeLorenzo, P.A.'s Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I may contact the office at (561) 306-1499.

Termination of Services: Services will be terminated upon mutual agreement between client and therapist based on need for continued services, transfer to another treatment setting or specialized treatment. If client has not scheduled an appointment within 60 days of the last office visit, he/she is considered officially discharged from this practice.

Name: First & Last (printed): ______________________________

Partner Name: First & Last (printed): ______________________________

Name of Paying Party: ______________________________

Relationship to Client: ______________________________

Signature: ______________________________

Date: ______________________________