STEPS
STRESS & TRAUMA EVALUATION AND PSYCHOLOGICAL SERVICES

OFFICE POLICY AND TREATMENT AGREEMENT

Please read the following agreement carefully, fill out and sign all indicated fields:

1. All cancellations, no matter what the reason, must be made 24 hours in advance, otherwise you will be charged the full session fee. Certain exceptions may be made at the therapist's discretion, but if you miss a session or cancel within less than 24 hours, please be prepared to pay the full fee for the session.
2. Sessions are scheduled for 45 to 60 minutes, depending on therapeutic modality and your agreement with your therapist. If you come late to session, we are unable to adjust our schedule.
3. It is understood and agreed that the client should give feedback, both positive and negative, to the therapist to maximize treatment benefits. It is further agreed that if you wish to terminate treatment at any time, or even reduce frequency of visits, you will discuss it with the therapist.
4. You agree to follow the verbal treatment plan formulated by the therapist. If you do not follow the treatment plan, the therapist has the right to terminate treatment.
5. Payment is expected at the time of the office visit. Bounced checks will require a $25.00 bounced check fee.
6. At this time the STEPS Stress & Trauma Evaluation and Psychological Services does not accept insurance. However, many insurance companies have out of network benefits that will reimburse a large percentage of the costs of quality care. Upon request, we can provide you with an invoice, which you can submit to your insurance for reimbursement.
7. It is your responsibility to cover the cost at the time services are rendered. We will accept a personal check, cash, or credit card payment. In order to ensure that we will be reimbursed in a timely manner, we ask that you provide a credit card that you authorize us to charge if we do not receive payment from you within 30 days of rendered services or a missed session with less than 24 hours' notice.

I understand and agree with the terms of the above treatment agreement and hereby authorize you to charge my credit card for professional services rendered if I fail to provide payment within 30 days of receipt.

Signature:_____Date:_____

Name:_____

Name of patient /if signed on their behalf/:_____

Relationship to the patient /parent, legal guardian, personal representative, etc./:_____

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Clinician Initials:_____ Date:_____

Credit Card information (VISA, MASTERCARD, DISCOVER):

Type of Credit Card: _____

Credit Card Number: _____

Expiration Date: _____

Security Code: _____

Billing Zip Code: _____

Name on Card: _____

Signature :_____Date:_____

Name:_____

Name of patient /if signed on their behalf/:_____

Relationship to the patient /parent, legal guardian, personal representative, etc./:_____