ELLEN K. SLICKER, Ph.D.

LICENSED PSYCHOLOGIST/HSP

PLEASE READ CAREFULLY – SIGNATURE IS REQUIRED

Each of the practitioners working in this office is a licensed clinician with separate national provider and tax identification numbers. They also have separate professional liability insurance. Each clinician is responsible for her own scheduling, medical billing, and collection of payment.

Professional counseling services by Dr. Slicker are provided to the patient, not to the insurance carrier. Every attempt will be made to verify coverage and benefits and to secure reimbursement, **but this in no way releases the client (or client's guardian) from responsibility for payment**. All insurance companies have a disclaimer stating that there is no guarantee of payment. In the event that the insurance company fails to pay, you will be held responsible for the balance. By signing below you are guaranteeing the following:

My payment of _____is due at the time of service, after my deductible of _____ is met.

I authorize this office and/or its billing office to release any information necessary to expedite the filing of claims. I authorize payment from my insurance carrier directly to Ellen K. Slicker, Ph.D. In the event I receive payment from my carrier, I agree to immediately provide such payment to Dr. Slicker.

The therapy "hour" is 45-50 minutes long. If you have an important issue to discuss, please mention it at the beginning of your session. Because therapist's time is limited I understand that there is a charge for telephone, text, or email consultation prorated at $25 for each quarter hour or portion thereof.

I authorize Dr. Slicker to release information to another medical professional for the purpose of consultation or referral in order to enable my best possible care. A photocopy of this authorization shall be as valid as the original. Information in your medical record is highly confidential and will only be released as stated herein and in accordance with the Federal Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that we safeguard your Protected Health Information (PHI), keeping it confidential except as required by law. A complete notice of HIPAA privacy practices is available to you upon request. A signed release of information is mandatory for release of any of your PHI except as stated above.

I agree to a charge of $45 for any missed appointment not canceled 48 hours in advance. The second time, and subsequent times, this happens, the fee is $70. This fee is not billable to my insurance co. Future appointments will not be scheduled until these fees are paid.

BY SIGNING BELOW, I CONFIRM THAT I HAVE CAREFULLY READ & AGREE TO ALL THE TERMS ABOVE AND HAVE HAD THE OPPORTUNITY TO DISCUSS ANY QUESTIONS OR CONCERNS and TO MAKE FURTHER INFORMATION REQUESTS. I UNDERSTAND ALL AREAS COVERED AND GIVE MY INFORMED CONSENT TO PARTICIPATE IN THIS TREATMENT PROCESS.

_____ _____

Signature Date