PSYCHOLOGICAL SERVICES FOR FAMILIES
410 North A Street
Oxnard, CA 93030
805-487-2244 Fax 805-487-2255

OFFICE POLICIES

Payment: Co-payment or full payment for service is due at the end of each session unless other prior arrangements have been made. Please notify us if any problem arises during the course of therapy regarding your ability to pay for services and/or co-payments.

Insurance: We will bill your insurance company for services. Please notify us if you change insurance companies or no longer have insurance coverage. At intake, please have your insurance card ready for copying.

Cancellation: To avoid being charged ($60) for a missed appointment, please call at least 24 hours in advance of any appointment you must miss. *** PATIENT RESPONSIBILITY* WE HAVE THE RIGHT TO REFUSE ANY MORE APPOINTMENTS AFTER 2 NO SHOWS.

I authorize Counseling Services for Family and Children to charge my credit card in the event that I miss my appointment and that I have not called with in the 24 hours that are stipulated in the agreement above.

Confidentiality: All information disclosed within sessions, including that of a minor, is confidential and may not be revealed to anyone without written permission **except** where disclosure is permitted or required by law. Disclosure may be required in the following circumstances:

1. When there is reasonable suspicion of abuse of a child or a dependent or elder adult.
2. When the client communicates a threat of bodily injury to others.
3. When the client is suicidal.
4. When disclosure is required pursuant to a legal proceeding (e.g., court subpoena).

Our *Notice of Privacy Practices* (attached) provides specifics on safeguarding your information.

Emergency Procedures: If you need to contact us between sessions, please call the office phone number. If you cannot reach us, please leave a message. Reasonable effort will be exerted to return your call as quickly as possible.

If you cannot reach someone in our office **and/or** it is a true emergency, please **call 911**.

I acknowledge that I have carefully read and understand the above policies and procedures and agree to comply with them

_____	_____	_____
PRINT NAME: *Client or Parent/Guardian*	DATE	SIGNATURE
_____	_____	_____
PRINT NAME: *Client or Parent/Guardian*	DATE	SIGNATURE