KEITH J. ANDERSEN, Ph.D.
Clinical Psychology
PSY 14114
P. O. Box 873
Bishop, CA 93515
760:873-6712

OFFICE POLICY

PAYMENT FOR SERVICE: Patients are expected to pay for services at the time they are rendered including insurance co-payments.

INSURANCE REIMBURSEMENT: Patients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. Dr. Andersen will provide you with a receipt that you can submit to your insurance company for reimbursement. If the insurance company has forms for the psychologist to complete, be certain to give them to our office at your earliest convenience.

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24-hours notice is required to reschedule or cancel an appointment. There are no exceptions to this policy. ***The full fee of $100.00 will be charged for missed appointments without such notification. In the event Dr. Andersen cancels your appointment without a minimum of 24-hours notice he will reimburse you directly the sum of $100.00.***

CONFIDENTIALITY: All information disclosed within sessions is confidential and may not be revealed to anyone without written permission except where disclosure is required by law. Additional exceptions include providing the results of treatment to your referring physician with your permission. Disclosure may be required in the following circumstances: Where there is a reasonable suspicion that the patient presents a danger of violence to others or where the patient is likely to harm him or herself unless protective measures are taken. Disclosure may also be required pursuant to a legal proceeding.

DELINQUENT ACCOUNTS/RETURNED CHECKS: Accounts that have not been paid within 30 days of service will be sent to a collection agency unless prior arrangements have been made. No clinical information will be provided to the collection agency. A $20.00 charge will apply to all checks returned from the bank for any reason.

I have read and understand Dr. Andersen's office policies.

_____ _____
Print Patient Name Date

_____
Patient Signature (Parent Signature if patient is under 18 years of age)