ANAT JOSEPH LCSW PsyA
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Office Policy and Counseling Agreement

Please take a few minutes and read the following to avoid future misunderstandings.

I welcome you to my practice. In order to ensure that you receive the quality of service I would like to provide, I ask that you cooperate with me in the following ways:

Appointments:

Please arrive on time to avoid shortened sessions. If you cannot keep an appointment and wish to cancel, a 24 hours cancelation notice is required. This is because your appointment is reserved for you exclusively. Broken or canceled appointments without sufficient notice will be charged to **you** in full at the contracted rate.

Please provide your payment information here:

Name:_____
Credit card :_____, #:_____
Expiration Date:_____, Security Code:_____, Billing Zip code:_____

Insurance:
I encourage you to check with your health insurance re: your health plan and coverage prior to treatment. Please note, that you are financially responsible for fees not covered or reimbursed by them. Most insurance plans require co-payments. I ask that you pay your co- payment in full at the time of service.

*Additional fees apply for written reports or professional consultations. These services are not included in the session fee nor covered by insurance, and will be charged at an hourly rate.

Should you have any further questions re: your treatment, payments and insurance information or other services available to you and your family- please don't hesitate to discuss them with me.

Thank You.

I have read and understood the Office Policy and Counseling Agreement. By signing below I have agreed to the terms outlined above.

_____ _____ _____
Name Signature Date