

**Policies, Procedures and Costs**

As a client of Symmetry we have an agreement with you concerning our practices and the manner in which we charge for our services. Please acknowledge your consent and agreement to these policies, procedures and costs as shown below:

You give consent to be evaluated by providers at Symmetry Counseling, LLC. For a list of current providers, please visit our website at [www.symmetry-counseling.com](http://www.symmetry-counseling.com).

**If your situation involves feeling that someone is at risk and you cannot reach our office, you agree to go to the nearest emergency room or call 911.**

Symmetry Counseling is an out-of-network provider for all insurances. This choice helps our practice minimize paperwork and maximize clinical benefit. Our current rate per 50 minute session is $\_\_\_\_\_\_\_.

We do not participate in ANY insurance or disability documentation, paperwork, reports, or telephone communication. In the case that we agree to fill out paperwork of any kind, there will be a $25 fee per 15 minute increments of time. If you request and submit a Superbill for insurance reimbursement, checks should be made out to and mailed directly to you, the patient. ANY checks received by Symmetry Counseling will immediately be voided and discarded. When speaking to your insurance company about reimbursement, make sure that this information is added to your file. If you need a receipt for insurance purposes (Superbill) please email your request after the session to your therapist. It is possible that your insurance company will not accept a Superbill alone for reimbursement. Please check with your insurance company ahead of time if this is an issue. We do not fill out CMS 1500 forms.

Symmetry Counseling strives daily to meet the needs of its diverse client population. Sliding scales are done on limited basis and are to be discussed with your individual therapist.

You authorize Symmetry, its therapists and agents to charge the following credit card for all charges incurred by the patient in connection with charges for Symmetry services. All charges, including charges for missed or cancelled sessions, documentation or other services described herein are authorized to be charged against this card.

Card Type: Visa MasterCard

Credit Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CSC (3 digit code) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name as it appears on card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of card holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Standard therapy appointments are 50 minutes in length.

Online sessions are not an option for every patient and it’s appropriateness must be evaluated by the clinician. Additionally, the therapist may determine at any time that online therapy should be changed to therapy-in-person.

If you miss an appointment or have an outstanding balance, you are required to pay the balance plus associated late fees prior to attending your next session.

Appointments are scheduled individually and, optimally, cancellations will be made 48 hours in advance. Please cancel at least 24 hours in advance to avoid being billed for a missed session. Missed sessions must be paid in full prior to attending another appointment.

You will be billed in full for sessions that are not cancelled at least 24 hours prior to your scheduled appointment. There are no exceptions to this rule (see billing and cancellation policy). If you are able to schedule another appointment that you attend on the same day as your missed appointment, you will only be billed for one session.

Missed sessions must be paid within 24 hours or a **$10 late fee** will be added to your balance and each week it remains unpaid thereafter. There is a one-time $50.00 fee for returned checks after which a late charge of $10.00 per week will be charged until payment is made. If your check is returned, you will need to pay online or in cash for all future appointments.

In the case of non-payment, your billing information may be submitted to a third-party collections agency after 30 days with an additional $50 collections fee.

In the case that your credit card on file is declined, you may avoid late fees if you pay within 24 hours of appointment time. You will be required to either place another card on file OR pay a retainer equivalent to 1 full session.

If you are late for your appointment your session will likely not be extended.

If you are more than 15 minutes late for your appointment, your session may need to rescheduled. It is our intention to be available to our clients during scheduled individual and group sessions. Please note that if weather becomes inclement for any reason (i.e. snowstorm, ice storm, tornado, etc.) your therapist will contact you about making alternative arrangements for the session. If you and your therapist feel that an online session is appropriate, you will make those arrangements. If an online or phone session is not available, you and your therapist will work together to find an alternative meeting time. If there is inclement weather and you and your therapist are not be able to find an alternative meeting time, you will not be charged for the session.

If we are required to go to court regarding this matter; you will be billed at $400.00 per hour and $200.00 for travel and preparation time. Please note that none of our staff are trained in a forensic capacity, nor are we qualified to give legal advice. Please consult with your attorney regarding these matters.

Our therapists do not conduct therapy via email but will accept questions about scheduling, and homework.

There will be a charge of $0.25 per page for records release. Any fees associated with requests to outside providers for records will be billed to your account.

If you request a revision in your record, the original record will be preserved and your written request will be documented within. The original record will not be altered.

Tennessee law considers the relationship and communications between therapist and patient to be privileged and confidential. However, in the case of an emergency, when there is imminent danger to the patient or another person, we may break confidentiality. Additionally, Tennessee law requires that child or elder abuse be reported to the Department of Human Services. Your confidential information will also be protected under federal HIPPA regulations. In all other cases, your information will not be shared without your signed consent. **Information sent over email is not secure.** You consent to waive your confidentiality when communicating via email. If you text message one of our providers, you are consenting for that provider to respond via text.

acknowledge that the current methods of information transmission are not fully secure. I am aware there is a risk to my confidential information each time I send an email, make a phone call, or transmit information in any way. With this understanding in mind, I consent to participate in an online session when an in-person session is inaccessible.

In order to maintain a peaceful and quiet atmosphere conducive to therapy, we ask that children under the age of 10 not be left in the waiting room during sessions. Please help us maintain a peaceful environment in the waiting area.

Phone calls that are not related to appointments or payment of fees are subject to a charge of $10.00 every 1-15 minutes.

Our office tries to return messages within a 4-hour period (during business hours). If you send an email or call our office after 5:00pm, staff will likely return your call or message the following day.

By signing below, I indicate that I have read the above practice policies, understand them, and agree to receive treatment within the provisions set out above. A copy of this form will be provided to me.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor Information (complete only if the patient is NOT paying for the bill):

Name of party responsible for bill: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\\_\_\_\_\_\_\\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor-Financial Responsibility Agreement:

I, the undersigned, regardless of any insurance coverage, am financially responsible for all charges generated for this patient. Office policy requires payment at the time of service. I understand that unpaid balances over 30 days may be subject to a late fee. I understand that unpaid balances over 90 days past due may be referred to a collection agency. I authorize Symmetry, its agents and therapists to charge all such expenses and costs to my credit card, listed above, in accordance with these policies and procedures.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_