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Clinical Psychology
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OFFICE POLICIES

I, _____, understand that I have an obligation to notify
Patient Name
Dr. Pilavian 24 hours in advance in case I want to cancel my appointment.

I understand that if I fail to give a 24-hour advanced notice and the office **will charge me** an amount of **$75**.

I understand that if I miss three consecutive appointments without notifying Dr. Pilavian, I will be discharged, thereby my treatment will be terminated.

(*If you have insurance please continue to read and consent)* I also understand that in the event my insurance carrier does not cover my psychotherapy or expenses involved in **psychological/neuropsychological evaluation**, **I am responsible to pay these expenses**.

(*If you are an out-of-pocket payer, please continue to read this paragraph*) I understand that I am responsible to pay all my psychotherapy expenses, with the fee we agree upon at the onset of the therapy agreement.

During the therapy sessions, I agree to turn off my mobile/cellular telephone to avoid distraction and maximally benefit from my treatment.

I understand that the office will charge me an amount of **$75.00** fee for producing an extensive psychological report. For shorter reports, the fee is **$30.00**. I also understand that an extensive report will be prepared within 15 business days; whereas a shorter report will be completed within seven business days.

By signing below, I confirm that I read and understand the abovementioned policies and hereby agree ☐ disagree ☐

_____ _____
Patient's Signature Date