WELCOME TO THE OFFICE OF JOYCE A BABB, MSW, LCSW, BCD
We are committed to promoting your personal growth and wellness through our mental health services. Here is some information to answer common questions about office procedures and financial arrangements.

HOURS AND CANCELLATIONS
Full sessions are typically 50 minutes. Appointments are scheduled directly with each therapist. If it becomes impossible for you to keep an appointment, please give AT LEAST 24 HOURS notice in order to avoid being charged for a late canceled session. Insurance does not reimburse for missed sessions; the client/guarantor may be charged the full session fee for late canceled appointments.

FEES AND INSURANCE
Fees are consistent with standard psychotherapy fees in the community. It is the client's responsibility to learn about any qualifications, limitations and mental health benefits available through their insurance plan. We will file claims to insurance companies with which we are under contract. Clients will be responsible for any applicable deductibles, co-pays, and co-insurances. Many insurance plans for which we are nonparticipating providers will reimburse you for some or all of the services received at our office. Clients can request from us a receipt for services provided and fees received to attach to claims to submit to their insurance plan for reimbursement. We suggest that clients send a photocopy and retain the original for their records.

EMERGENCIES AND PHONE CALLS
In the event of an emergency, call 911 or go to your nearest emergency room. If there is an urgent matter and you need to reach your therapist before your next scheduled session, please call the office and leave a message as to where you can be reached. Extended phone consultations outside of scheduled sessions may be subject to a fee.

CONFIDENTIALITY
We are committed to making our office a safe place for you to get help. To that end, we adhere to all legal protections of your privacy.

COMMUNICATION
Good communication between us is vital to our ability to serve you well, so do let us know about any problems and questions that might come up.

AGREEMENT/ASSIGNMENT AND RELEASE
I, the undersigned, certify that I have read and agree to the above policies. I also agree that I am personally and wholly financially responsible for all charges incurred, and will assure that full, timely payment is made to our office for all services.

I further hereby authorize the therapist or office representative to release to my insurance company or its affiliates all information necessary to process my service claims to secure the payment of benefits and assign these benefits directly to my provider. If my provider is not under contract with my insurance company, however, and I submit claims for reimbursement, I authorize my therapist or office representative to release to my insurance company all information necessary to process my claim for reimbursement to me. I authorize the use of this signature for this purpose and a copy of this signature is as valid as the original.

_____	_____	_____	_____
Patient Printed Name	Guarantor Printed Name Person financially responsible	Guarantor Signature	Date