Individual & Family Therapy

Holly R. Dunn MSW, LCSW
Holly Rothenbush LMFT, BCBA
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(260) 436-1131

STATEMENT OF UNDERSTANDING

Thank you for selecting Holly Dunn, MSW, LCSW or Holly Rothenbush LMFT, BCBA for your therapy needs. So that we may prevent any misunderstanding regarding our policies, we request that you read and sign this explanation of our policies.

PAYMENT POLICY

The client is responsible for payments at the time services are rendered. All co-payments are due at time of service, without exception. All therapist accept cash and personal checks. A $25.00 service charge will be assessed for returned checks.

Therapist realize in some cases that mental health care can be unexpected and costly. In some exceptional situations, we will discuss acceptable financial arrangements with you prior to leaving the office.

Therapist are contracted with several insurance companies and as a courtesy to clients who are covered by those companies, we submit insurance claims for services rendered. Presenting your insurance card(s) will allow us to verify whether or not your insurance carrier is one with which we routinely file claims. **Failure to present all insurance information at the time of service (primary, secondary and EAP) may result in the loss of your benefit.** If your health insurance carrier is not one of the companies with which we routinely file, you will be provided with the necessary documentation of the services rendered so that you can file with your insurance carrier. Any problem with your insurance carrier that delays or prevents payment of claims is the client's responsibility. Delayed processing and payment by your insurance company is not a reason for delayed payment to therapist. Deductibles on your insurance policy require full fee payments until it is met. In order to utilize your insurance, your signature is required on the Initial Contact Form.

Referral to our professional collection service will be made for accounts with balances older than three (3) months and when the client has not made firm credit arrangements with us.

PRIVACY

You have been provided with the HIPAA Notice of Privacy Practices. Please read it carefully and sign the acknowledgement form.

SESSIONS

A typical therapy session in this office lasts 45 -50 minutes. Therapy requires your very active involvement and efforts to change your thoughts, feelings and behaviors. There are no instant, painless or passive cures. Sometimes people change in therapy and sometimes they do not.

CANCELLATIONS

As a courtesy to other clients, we would appreciate cancellations to be made 24 hours prior to your scheduled appointment. Our policy is to assess half of the full fee to the balance without 24-hour notification.

I have read and understand the policies as described above. By my signature below, I agree to the above office policies and agree to participate or have my child participate in mental health services offered and rendered by Therapist, mental health providers as defined in Indiana law.

I understand that I am consenting and agreeing only to those mental health services that the above named providers are qualified to provide within:

- the scope of the provider's license, certification and training; or
- the scope of the license, certification and training of those mental health providers directly supervising the services received by the client.

_____ _____

Client/Parent/Guardian Child's Name

_____ _____

Witness Date