INFORMED CONSENT FORM MASON ASSOCIATES LLC

Welcome!
Thank you for choosing Mason Associates LLC. This is an opportunity to acquaint you with information relevant to treatment, confidentiality and office policies. Your therapist will answer any questions you have regarding these policies.

Appointments
Appointments are scheduled for 50 minutes. Sessions will be scheduled to meet your individual needs.

Canceled or Missed Appointments
Your appointment time is reserved solely for you. Therefore, we request a 24-hour notice for any schedule changes that you may need in the future. Mitigating circumstances may be taken into account, we understand that sometimes emergency situations can arise. If the weather is questionable, we will give you a call to inform you of our status, reschedule, or make other arrangements.

We therefore reserve the right to bill at a flat rate of ***$65.00*** if you cancel a session with less than 24 hour notice or are a no-show to your scheduled session. With this in mind we want you to be informed of our appointment policy now, so there are no misunderstandings in the future. Thank you for your cooperation.

Reaching Us
A therapist can be reached through our office phone number 7 days/week, 24 hours/day. Our office hours vary. Should you need to stop by with insurance papers or for some purpose other than your scheduled appointment, we ask that you call first to be sure that a staff member will be present to assist you.

Confidentiality
Your confidentiality is one of our highest priorities. These policies were enacted under the legislation called HIPAA which stands for *Health Insurance Portability and Accountability Act.* A copy of our Notice of Privacy Practices is availale upon request. All of your treatment at Mason Associates LLC is kept confidential. No information will be released without your written consent unless your therapist feels you are a danger to yourself or others. Releasing information to any agency or individual will require a signed release of information. We want you to feel comfortable and satisfied with your care. If you have questions or concerns do not hesitate to ask any of our staff.

Insurance Payments
Our office will file your insurance claim, but you are responsible for deductibles, co-insurance, and co-payments. It is your responsibility to know who adminstrates your mental health benefits and if your mental health benefits are under your insurance policy. You will be responsible for payment of all services that are not paid by your insurance company, including denials for no preauthorizations.

The undersigned agrees to promptly pay all the charges when billed for services rendered, and become legally responsible for any and all charges occurred for the patient named above. I understand that my bill is a matter between myself and my insurance carrier. Any unpaid charges are due within 30 days of treatment. I understand that I will be responsible for any collection or court costs should my account be turned over for collection.

Agreement of Policies
Signing below indicates that I have read, understand and agree to the policies in this document.

_____ _____
Signature Date

_____
Printed Name