***Ann Marie Buckley, LCSW, PLLC***

***730 N. Post Oak Road, Suite 301***

***Houston, TX 77024***

***General Policies***

FEES: Therapy sessions typically last about 45-50 minutes. Fees are paid at the time of the session unless other arrangements have been made in advance. A monthly statement will be provided if requested, showing dates of service, charges, fees, payments made, etc. Accounts delinquent over three months ***will be sent to collections.***

APPOINTMENTS: Appointments are usually scheduled on a first- come, first-served basis. However, standing appointments can be arranged. It is requested that changes and cancellations be made at least 24 hours in advance so that time may be made for someone else. **PLEASE BE ADVASED THAT YOU ARE FINANCIALLY RESPONSIBLE FOR ALL SCHEDULED APPOINTMENTS UNLESS A 24 HOUR CANCELLATION NOTICE IS GIVEN VIA PHONE OR EMAIL. PLEASE NOTE THAT INSURANCE CLAIMS THAT HAVE BEEN DENIED BY YOUR INSURANCE COMPANY OR REMAIN UNPAID FOR A 45 DAY PERIOD OF TIME WILL BE BILLED TO YOU DIRECTLY.**  If it is possible, as per therapists, schedule, to reschedule your cancelled appointment within the same week, there will be no charge for late cancellations.

**CONFIDENTIALITY:** I am required to safeguard your privacy. All conversations and written material regarding client remains confidential. Current written permission from you will be necessary for any records to be released. Only under very serious and specific circumstances or legal situations will exceptions to this rule be taken. Exceptions to confidentiality may include but are not limited to: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; child custody cases, or court order. Should you choose to utilize insurance benefits or a plan whose benefits are managed, please be advised that we may be required to release clinical information to personnel involved in managing your care for you to receive maximum benefits. If this is the case, your confidentiality may be affected. If you have any concerns about this, please talk to your therapist.

**I certify that I have read and understand the General Policies:**

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Signature Date

Consent to treat a minor:

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***Insurance Assignment: I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to above noted therapist.***

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***Signature Date***