INNERACTION Therapy for Inner Well-Being and Interpersonal Success

OFFICE PRACTICES

Please read the following carefully.

Sessions for individuals are billed at $120.00 per hour. Mediation/co-parenting, and couples/family therapy sessions with 2 or more participants are billed at $130 per hour. Payment is expected by **cash or check** at the end of the appointment. Upon request, a super bill can be provided for you, which can be used for insurance billing and/or as a receipt for services.

You are ultimately responsible for the total cost of services, if for any reason a third party payor (insurance company, PPO, EAP, or victims assistance program) fails to provide payment. A $15 fee is charged for returned checks, and a 3% monthly service charge will be added for balances held for over three (3) months.

Your appointment time is scheduled just for you. To cancel an appointment, please leave a message at (530) 587-1978. **Twenty four (24) business hours** in advance notice of cancellation for **50 minute sessions** and **forty-eight (48) business hours** in advance notice of cancellation for **two (2) hour sessions** is required to avoid paying the full fee for a missed appointment. A storm warning is the only exception for missed appointments without notice. In such instances, please call as soon as possible to notify me that you are unable to come and to arrange another appointment. Insurance plans do not provide coverage for missed appointments; therefore, you will be personally responsible for fees resulting from missed appointments without notice.

To reach me by phone, please call 530.587.1978. If I am out of town, and you are in need of assistance, you may call the Community Help Line of Tahoe Women's Services at 800.736.1060 or Nevada County Mental Health Crisis Line at 530.265.5811. In an absolute emergency, please call 911. My private email address for confidential communication is pollyryanmft@gmail.com. For all scheduling needs and billing questions, please use inneractiontherapy@gmail.com.

Please feel free to ask me about your treatment plan or my evaluation of your progress. Our conversations are confidential. I will not tell anyone else what you have said without your consent unless you may be a danger to yourself, another person, or me. I am also required by law to report situations of suspected child abuse or neglect.

I authorize payment of counseling benefits payable under my insurance program to the provider named above. I am solely responsible for any required co-payments to the provider, and it is agreed that payments will not be delayed or withheld because of insurance coverage or the pendency of claims thereon. I also authorize the exchange and/or release of information required to process insurance claims or for ongoing Utilization Review. In the event that legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I also agree to pay reasonable attorney's fees or other such costs as the court determines proper.

I have read and understand the office practices and agree to work within these guidelines.

Name **Date**

Polly M Ryan, MA, MFT, PO Box 2315, Truckee, CA 96160 530.587.1978