Office Policies
Roma Palcan, Ph.D.

Counseling Services are to be paid for at the time they are rendered. If for some reason fees have not been paid, therapy will be suspended until your account is paid in full.

Therapy sessions are 50 minutes in length. To preserve our session time, please arrive before your scheduled appointment time. Payment is expected upon arrival. You may discuss with Dr. Roma Palcan telephone and half session options. Telephone sessions are billed at the same rate as an office visit.

If you need to cancel an appointment, please make sure to do so at least 24 hours in advance. Your appointment time is reserved just for you and rescheduling that time for another individual is often not possible without adequate notice. **Therefore, if you miss or fail to cancel an appointment within 24 hours of the scheduled time, you will be charged $200.00. In cases of emergency, the fee will be waived.** You can call me at 727-895-4500 and leave a message regarding your appointment anytime.

A $25.00 service charge will be billed on all returned checks.

Confidentiality: The contents of counseling, intake, or assessment sessions are considered to be confidential. Both verbal and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. However, I do reserve the right to consult with professional colleagues about my work with you, but I would do so in a way that preserves your anonymity. Please refer to the "Notice of Privacy Practices" in the blue binder in the lobby for a complete list of exceptions to confidentiality.

Informed consent: I authorize Dr. Roma Palcan to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the insurance company for the purpose of receiving payment directly to Dr. Roma Palcan. I understand that access to this information will be limited to determining insurance benefits, and I understand that I may revoke this consent at any time by providing written notice. Further, I authorize this form to be used on all insurance submissions related to my account. *I understand that it is my responsibility to pay any deductible or copay at the time service is provided. I understand that I am required to pay the balance of my account if the bill is not covered by my health insurance.*

I understand that I am entering into a voluntary confidential therapeutic relationship with Dr. Roma Palcan and that confidentiality will be maintained unless I pose a danger to myself or others or I report any suspected abuse of a child, elderly person or individual with a disability. I certify that I have read and agree to the conditions above and received a copy of this form. By signing below I (please print) _____, am indicating that I both understand and agree to all of the above.