Dr. Michele Durrance-Miller Psy.D.
Licensed Psychologist

OFFICE POLICY FORM

CONSENT FOR TREATMENT: I hereby consent to receive psychological services from Dr. Michele Durrance-Miller, Licensed Psychologist. I acknowledge that I have had the opportunity to ask questions regarding the evaluation and treatment process.

PAYMENT FOR SERVICE: Patients are expected to pay fees at the time services are rendered. Please notify Dr. Durrance-Miller if any problem arises during the course of your therapy/evaluation regarding your ability to make timely payments. In the case of an evaluation, no reports will be released until full payment is made. Fees are set in accordance with the type and extent of psychological services that are conducted. The fee for a returned check is $30. If payment is not received within 90 days, or monthly payments are not made as agreed, Dr. Durrance-Miller may submit the invoice to an attorney or collection agency. All psychological evaluations include a clinical interview, psychological testing, a copy of the final report, and a feedback session explaining the results. If further testing is indicated and agreed upon, additional fees will apply. No refunds will be provided for services rendered. Fee for Current Treatment/Evaluation: _____.

INSURANCE REIMBURSEMENT: Patients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. You will be provided with a receipt that you can submit to your insurance company for reimbursement. If the insurance company requires the psychologist to complete forms, be certain to give them to Dr. Durrance-Miller at your earliest convenience. In instances where extraordinary professional time is required, you may incur additional fees.

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48-hours notice is required for rescheduling or canceling an appointment. The full fee may be charged for missed sessions without such notification.

CONFIDENTIALITY: All information disclosed within sessions is confidential and may not be revealed to anyone without written permission except where disclosure is required by law. Disclosure may be required under the following circumstances: Where there is a reasonable suspicion of child or elder adult abuse. Where there is reasonable suspicion that the patient presents a danger of violence to others or where the patient is likely to harm him or herself unless protective measures are taken. Disclosure may also be required pursuant to a legal proceeding.

ELECTRONIC COMMMUNICATION: Clients are welcome to email/message Dr. Durrance-Miller regarding scheduling and for brief follow up messages. However, please understand that Dr. Durrance-Miller cannot guarantee confidentiality to be 100% protected via electronic communication. Please avoid sharing confidential information electronically. If an emergency arises, please follow the emergency procedures below.

EMERGENCY PROCEDURE: If you need to contact Dr. Durrance-Miller between sessions, please leave a message at (813) 421-2192. Please do this for true emergencies only.

PRIVACY PRACTICES: I acknowledge that I have reviewed the Notice of Privacy Practices, which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the psychologist is not required to agree to the restrictions I request.

I have read and understand these office policies.

Client Name Printed	Date	Signature

Parent (Guardian) Name Printed	Date	Parent Signature

205 South Hoover Blvd. Suite 204
Tampa, Fl. 33609
(813) 421-2192
www.tampabaytesting.com
DrDurrance@me.com