

Jennifer S. Grellman, MS, LMFT

Licensed Marriage and Family Therapist #52905
Adolescent and Family Psychotherapy
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OFFICE POLICIES AGREEMENT

This document contains important information about Jennifer Grellman's office policies. Please read it carefully and ask Ms. Grellman any questions that arise. Signing this document represents an agreement between you and Jennifer Grellman, honoring these policies.

PROFESSIONAL FEES: The fee for a 50-minute session of individual therapy is \$____. The fee for a 75-minute initial evaluation is \$____. Fees for longer or shorter sessions will be prorated from this amount. There will be no charge for brief telephone calls that are 10 minutes or less, such as those made to schedule appointments or clarify an assignment. However, you will be charged the typical session fee (prorated according to length) for calls longer than 10 minutes. Other services include telephone consultations, report writing, or other services you may request. If you become involved in legal proceedings that require Ms. Grellman's participation, you will be expected to pay for the professional time she spends preparing records or treatment/assessment summaries. You will also be expected to pay for her time spent testifying, even if she is called to testify by another party. There is typically a small increase in fees each year around January 1 and/or July 1.

BILLING AND PAYMENTS: Payments are to be made at the beginning of each session. In order to expedite the payment for your services, it is preferable to get the information of your credit card at the first session to charge if a payment is missed (this includes the name on the card, credit card number, 3-digit code on back of card, billing address, and phone number). This information will be kept in a secure Internet server, similar to if you chose to have Amazon.com store your credit card for future purchases. If you prefer to pay by check, there is a \$30 fee for returned checks. An additional charge of \$50 will accrue monthly for any unpaid balances. If your account has not been paid for more than 60 days, Ms. Grellman may use legal means to secure the payment. This will involve either hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information Ms. Grellman releases regarding a client's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT: Ms. Grellman does not take insurance at this time. Certain health insurance policies will provide some coverage for "out of network" mental health treatment, however, you (not your insurance company) are responsible for full payment of fees at time of service. Per your request, she will provide you with an invoice that contains information your insurance company may require, however, it will be your responsibility to complete insurance forms and obtain reimbursement. If you intend to be reimbursed by your insurance company for the fees you pay, it is very important that you find out exactly what mental health services your insurance policy covers

CONTACT INFORMATION/E-MAILS: If you (your child) need to contact Ms. Grellman between sessions, you (your child) can reach her by phone by calling the office number (415-306-6768) or by email (jgrellman@comcast.net). Voice and email messages are checked several times a day and you will be called or emailed back as soon as possible. If she doesn't get back to you (your child) within a reasonable amount of time, please call or email again because sometimes messages don't arrive in her email inbox or are not clear in voicemail. *A warning about email:* if you (your child) engage(s) via email about treatment, you are releasing her from any liability for protecting your confidentiality because email cannot be transmitted on a secure server. Although every effort is made to provide the highest security available (i.e. password required to access her computer and her internet connections), by emailing with Ms. Grellman, you (your child) are (is) consenting to this risk.

SCHEDULING APPOINTMENTS: Ms. Grellman recommends that in order to maintain you (your child's) commitment and focus to treatment, that you arrange a predictable weekly session time during the duration of treatment. If you wish to schedule a different appointment time please see Cancellation Policy below.

WAITING LIST: If at any time a person prefers a time that is occupied by another client, Ms. Grellman will first approach that client to see if a change is possible. If not, she can add the person to the waiting list for that time and when it becomes available, she will offer that time to the next person on her waiting list.

EMERGENCIES: Ms. Grellman's voicemail and email are not emergency resources because she only checks messages a few times/day. If you (your child) are (is) in crisis, you can access your (your child's) primary care physician, the local emergency room, or crisis intervention services. You can call the 24- hour Psychiatric Emergency line in Marin (415-499-6666) or the police at 9-1-1. When Ms. Grellman is out-of-town or unavailable due to an urgent matter, she will let you know and will give you the name and telephone number of another psychotherapist who will be available to her clients for emergencies.

CANCELLATIONS, MISSED SESSIONS, AND TARDINESS: Once an appointment is scheduled, you will be charged for it unless you provide 48 hours advance notice of cancellation. Ms. Grellman requires 48 hours in order to offer the appointment time to another client. Generally sessions will start on time. Sessions will end at the scheduled time, even if you (your child) are (is) late. If Ms. Grellman begins a session late, she will make up the missed time in some mutually agreeable fashion (e.g., by extending the session or adding the missed time to the next session, if convenient for you).

I have read and understand this Office Policies Agreement and I have had my questions answered to my satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement. I consent to respect and honor these business policies.

Initials: _____

Name of patient/client (please print): _____

Name of parent/guardian, if applicable (please print): _____

Address: _____

Phone Numbers: _____

Signature of patient/client/parent/guardian:

Date: _____

I hereby authorize Ms. Grellman to take the information of my credit card and charge it according to the policies explained in this agreement.

Signature of patient/client/parent/guardian: _____