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914-570-0134•INFO@OMNIPSYCHOTHERAPY.COM

INFORMATION ABOUT PROCEDURES AT OMNI PSYCHOTHERAPY, LCSW. P.C.

DATE: ______________________

NAME: ____

ADDRESS: ____

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SSN: ____

THE INTAKE INTERVIEW: In this interview your presenting problems are explored and evaluated. Recommendations for treatment are given. It is occasionally necessary for this interview to be followed-up by supplementary diagnostic work. Findings and recommendations will be fully discussed with you.

YOUR APPOINTMENT: Sessions are planned exclusively for you and time is allotted accordingly. If sessions are not canceled within forty-eight business hours of appointment time, you will be responsible to pay the full session fee of $225.00. A pattern of cancellations, two late-cancellations, or two no-shows will result in termination of therapeutic services.

INSURANCE: It is the patient's responsibility to know the limits of their health plan coverage for mental health. Co-pays are due at the time of visits. Any unpaid balances or deductibles for services rendered at Omni Psychotherapy, LCSW, P.C. are the patient's responsibility. If, for any reason, insurance checks are made payable to the patient, it is the patient's legal responsibility to endorse checks to Omni Psychotherapy, LCSW, P.C. upon receipt.

I hereby give my consent for Omni Psychotherapy, LCSW, P.C. to notify my primary care physician that I am in treatment.
________ Patient Refused

INSURANCE IS NOT A GUARANTEE OF PAYMENT

PATIENT SIGNATURE: ____

WITNESS: ____