Michael Sherman, MFT

# Office Policies



**Payment**

**Clients are expected to pay for services at the beginning of each session.** Please write your personal check prior to the start of your session. Our office does not accept payment via credit card. **There will be a $25.00 fee for returned checks.**

**Insurance Reimbursement**

Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company. Our office will bill a client's insurance provider for any portion of professional fees which may be a covered benefit. However, **payment of services which are not covered by their insurance carrier is the client's responsibility.**

**Confidentiality**

All information disclosed within sessions is confidential and may not be revealed to anyone without your written permission except where disclosure is permitted or required by law. Disclosure may be required under the following circumstances: where there is suspicion of child or elder abuse; where there is reasonable suspicion that the client presents a danger of violence to others or where the client is likely to harm him or herself unless protective measures are taken. Disclosure may also be required pursuant to a legal proceeding. Some information is shared among professional associates and staff within the group practice for purposes of insurance billing, record keeping, and collaboration to assist with treatment.

431 S. Palm Canyon Drive, Suite #214, Palm Springs, CA 92262
PH 562.434.5667 FAX 760.320.9096 msherman.mft@verizon.net
MFC 36194

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## Missed Appointments (initial where indicated)

1. As the scheduling of an appointment involves the reservation of time specifically for you, we will accept cancellation or rescheduling made **at least 24 hours prior to scheduled appointment.**

Initial _____

2. Session Fee is $175; **accommodations considered on an individual case basis**.

Initial _____

3. The full session fee is charged for **LATE** cancellation and **NO SHOW** appointments.

Initial _____

4. Please leave messages regarding appointment changes and cancellations at **562-434-5667.**

Initial _____

5. It is important to note that insurance benefits **DO NOT** apply to late cancellatuion and no show charges. **The session fee is solely your responsibility.**

Initial _____

**Signature:** _____

**Print Name:** _____

**Date:** _____

**Relationship to Patient:** _____

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