

WEST MICHIGAN PSYCHOLOGICAL SERVICES

259 Hoover, Suite 140
Holland, Michigan 49423
616-460-0174



WMPS Policy Information

We are thankful that you have chosen WMPS. We are committed to providing you with the highest quality professional and ethical treatment. Please understand that payment of your bill is considered part of your treatment. PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH OR VISA/MASTERCARD/DISCOVER/AMERICAN EXPRESS.

The following is WMPS's policy information, which we require you to **read, initial,** and **sign** prior to any treatment. If you do not understand, or if you have any questions, please ask.

Confidentiality _____

All information disclosed within sessions is confidential and may not be revealed to anyone without your expressed, written consent. There are exceptions to confidentiality, specifically IN CASES WHERE THE THERAPIST IS MANDATED BY LAW TO REPORT TO THE APPROPRIATE AUTHORITIES (i.e., WHERE THERE IS REASONABLE SUSPICION OF ABUSE OF CHILDREN, ELDERLY OR DISABLED PERSONS; WHERE THE CLIENT IS LIKELY TO HARM HIM/HERSELF OR OTHERS UNLESS PROTECTIVE MEASURES ARE TAKEN). If you have any questions about confidentiality, especially as it relates to children and adolescents, please ask your therapist. Please note that if you use insurance to help pay for your sessions, your signature on the bottom of our intake sheet grants the insurance company permission to request information about you from us.

Insurance _____

We participate with several insurance companies. Participation means that we will accept what your insurance company approves. You are responsible for any copays, deductibles or non-covered services at the time of service. If we do not participate with your insurance company you are responsible for the full fee at the time of service. We will turn in a courtesy claim for you to your insurance so that they can reimburse you directly, apply the visit to your deductible, etc.

Payment for Service _____

Payment is expected at the time of the scheduled session unless you request other arrangements. IF you are having difficulty paying your bill, please talk with us regarding payment arrangements. If we receive payment other than expected from your insurance company, the remaining balance will be transferred to your account. Any outstanding balance must be paid in full within 30 days. We will mail a statement to all clients who have a balance due on their account. If payment is not received within the calendar month, a \$10 statement fee will be assessed. If an account remains unpaid, we will pursue collection of this past due account.

Minor Patients _____

The adult accompanying a minor and/or the parents/guardians of the minor are responsible for full payment. For unaccompanied minors treatment will be denied unless charges have been pre-authorized to an approved credit card or payment is made by cash or check at time of service, unless prior arrangements have been made.

Cancellations/Missed Appointments _____

We request that appointment cancellations be made 48 hours in advance. Cancellations made less than 24 hours prior to the appointment or no-show appointments may result in a charge that may total the full fee of your appointment.

Client Acknowledgment and Agreement:

- I have read and understood the above information.
- I have had the opportunity to ask questions and have any questions answered.
- I agree to pay the fee for each visit for services rendered.

Signature of the patient or responsible party

Date

Signature of co-responsible party

Date