The Alliance for Eating Disorders Awareness Psychological Services
1649 Forum Place, Suite 10
West Palm Beach, Florida 33401

OFFICE POLICIES AND PROCEDURES

Thank you for seeking therapy with us. Prior to your initial session, we would like to clarify our office policies and explain how therapy is conducted.

1. Your therapeutic relationship is confidential. Records or information about your therapy will not be released without your permission. However, there are several legal limitations to confidentiality. If we believe that you pose a threat to your life, or to the life of another person, we are legally responsible for taking measures to prevent such action. This may include contacting appropriate authorities. In addition, if there is reason to believe that child abuse/neglect is occurring, we are legally obligated to report this to the appropriate authorities. This is for your own protection, and that of your family.

2. Therapy sessions are 45 minutes in length. Longer sessions may be scheduled at your request.

3. Fees are payable before or after each session. The current fee for your therapy session is _____. Payment can be made by cash or any credit card.

4. There is no charge for appointments cancelled at least 24 hours in advance. However, if you cancel the same day or if you fail to keep an appointment, you will be expected to pay for the missed session except in case of emergency. Our answering service will take messages evenings and weekends.

5. In case of emergency, your therapist is available by phone. In the event that your therapist is out of town, another therapist will provide coverage.

6. Your therapist is available for brief phone contacts between sessions. However, lengthy telephone calls (longer that 10 minutes), consultations, and correspondence will be billed at your therapy rate.

7. We do not believe it is advantageous to expect your therapist to testify in court. This interferes with the therapeutic process. All forensic work (e.g. depositions, testimony, court reports, research, correspondences, etc.) will be billed at the rate of 150% of your therapy fee.

Please sign below indicating you have read and that you understand and agree to the points above.

_____ _____
Patient Date

_____ _____
Witness Date