NATIONAL ALLIANCE
for Eating Disorders

NATIONAL ALLIANCE FOR EATING DISORDERS PSYCHOLOGICAL SERVICES OFFICE POLICIES AND PROCEDURES

Thank you for seeking therapy with us. Before your first session, please review our office policies.

1. The relationship with your therapist 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 and/or elder 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 each session. The fee for your therapy session will be discussed with your therapist. Payment can be made by cash, debit card, or credit card.
4. There is no charge for appointments cancelled at least 24 hours in advance. However, if you cancel the same day, or fail to show up for an appointment, you will be expected to pay for the missed session except in cases of emergency. Our answering service will take messages evenings and weekends.
5. In case of emergency, your therapist is available by phone. If your therapist is unavailable, another therapist will provide assistance. Alternatively, or if unable to reach your therapist, you can call 911 or 211.
6. Your therapist is available for brief phone conversations between sessions. Calls, consultations, and/or correspondence longer than 10 minutes, will be billed at your therapy rate.
7. We do not believe it is beneficial 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 Signature Date

_____ _____

Witness Signature Date