Robin Meade, Psy. D., Inc.
Licensed Psychologist
Certified Family Mediator
Licensed Mental Health Counselor
1215 Louisiana Ave, Ste 100
Winter Park, FL 32789
407-622-0825 fax: 407-622-0826

Office Policies and Procedures

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PATIENT NAME: (Please Print)

It is usual and customary for the provider and the Patient to agree upon fees by the first session. Patients are expected to pay at the time of service unless agreed otherwise. Initial consultations are 50 minutes long, subsequent individual sessions are 45-50 minutes long; double-sessions are 1 hour and 50 minutes in length.

Patients utilizing out-of-network insurance benefits: If Dr. Meade is an out-of-network provider for your insurance carrier, then you are responsible for making payment of the agreed upon fee for services at the beginning of each session. Our office can provide you with a receipt, which you can submit to your insurance company for reimbursement. Not all issues that are the focus of psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. For example, telephone conversations, emails, report and letter writing, consultation with other professionals, releases, completion of paperwork, longer sessions, travel time, etc., are not covered under insurance. These extra activities will be billed in 15-minute increments at the rates of $185-$200/hour or $275/hour for legal cases. There will be a minimum charge of $25 for completion of any paperwork requested by you.

RESPONSIBILITY FOR UNPAID BALANCES

Payment is due at the time of service. Outstanding balances must be paid in full prior to scheduling subsequent appointments.

Patient/Guardian's Signature: _____ Date: _____

NO-SHOW/LATE CANCELLATION POLICY

Please understand that last-minute cancellations and no-shows prevent others from obtaining much needed services. Thank you for your understanding.

I acknowledge my understanding that since my appointment time has been set aside exclusively for me, that I am responsible for notifying my practitioner at least 24 business hours in advance to avoid a $75.00 **No-Show/Late Cancellation Fee**. I am also aware that should I accrue two (2) **No Show/Late Cancellation Fees**, all subsequent **No Show/Late Cancellation Fees** will be charged the full billable amount of the session. Once a **No Show/Late Cancellation Fee** is charged, no future appointments will be scheduled until the fee is paid in full. I understand and agree that whether or not I receive a reminder call, I am responsible for my appointment and that my credit card may be charged for late cancellations and/or missed appointments.

Patient/Guardian's Signature: _____ Date: _____

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Patient Name: _____

CREDIT/DEBIT CARD ON FILE

It is preferable, although not required, for Dr. Meade's office to retain on file a credit/debit card number for all active patients. This information is kept strictly confidential and will only be used for payment of fees to Robin Meade, Psy.D., Inc.

I have read and familiarized myself with the Policies including Responsibility for Unpaid Balances and No-Show/Late Cancellation. I authorize Robin Meade, Psy.D., Inc. to charge my payment card for any and all outstanding balances on my account (i.e. phone calls, emails, No-Show/Late Cancellations, etc). **We accept Visa, MasterCard and Discover, only.**

Name of Cardholder (print): _____

Card Number __ __ __ __-__ __ __ __-__ __ __ __-__ __ __ __ Expiration Date: _____ CVC:_____

Signature of Cardholder: _____ Date: _____

RIGHT TO COLLECT INSUFFICIENT FUNDS

If payment is by check or credit card and either the check is returned for insufficient funds or the credit card is declined, I, _____, hereby authorize Robin Meade, Psy.D., Inc. to reveal my name and the fact that I sought professional psychological services from Dr. Meade to a collection agency or a court or both as necessary for Robin Meade, Psy.D., Inc. to collect the fee(s) due.

Patient/Guardian's Signature:_____ Date: _____

EMERGENCIES

Dr. Meade will make every effort to be available in case of emergency. However, since her practice is for outpatient services only, she is not accessible 24 hours a day. Therefore, if you should experience a crisis and Dr. Meade cannot be reached, please contact LifeLine of Central Florida at 407-425-2624, call 911, or go to your local emergency room.

PLEASE INITIAL: _____

VOICE MAIL/FAX/EMAIL

Confidentiality cannot be guaranteed via these mediums. Emails are retained in the logs of your and my internet providers and could theoretically be obtained by these providers. Please do not transmit personal information unless absolutely necessary. Please be advised that cancelling an appointment by fax or email is not valid because the message may not be received in a timely manner. Do not use emails for emergencies. If you do communicate via email, this will become part of your medical file. Please be advised that there may be a charge for communication from Dr. Meade that you request by email.

PLEASE INITIAL: _____

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Patient Name: _____

SOCIAL MEDIA

Dr. Meade cannot accept friend or contact requests from current or former patients on personal social media sites. This could compromise your confidentiality. Dr. Meade does not follow or make contact with current or former patients on any social media site.

PLEASE INITIAL: _____

HIPAA DISCLOSURE

As of April 15, 2003, the Health Insurance Portability and Accountability Act (HIPAA) will no longer permit us to leave messages to confirm appointments without your permission. If you would like us to contact you to confirm your appointment and/or leave you a message, please sign below. Please check your voice mail to ensure that the office is not calling you to cancel an appointment. Please be aware that the public areas of the building, though not Dr. Meade's office suite, have cameras installed for security purposes.

Patient/Guardian's Signature:_____ Date: _____

RIGHTS

As a patient, you have the right to receive available services individualized to your specific needs and provided in the least restrictive manner. You have the right to seek information about and to approve of the therapeutic process.

With limited exceptions, information discussed and recorded is confidential. You will be asked to provide written consent if information is to be released to third parties. The exceptions to the strict maintenance of confidentiality include: 1) information that is shared on a need-to-know basis during clinical supervision of the therapist's work, 2) imminent physical danger to self or others, 3) child abuse, 4) information legitimately ordered by a court of law, 5) information required by your insurance company in order to process a claim made by you, and 6) psychological test data and certain demographic information (no identifying information) may be used for clinical research purposes.

I, the undersigned, consent to mental health services. I am aware that the practice of psychology is not an exact science and acknowledge that no guarantee has been made to me as to the results of evaluation or treatment, the number of sessions necessary, or the total cost of all services. I understand that the office will make every effort to release only the minimum information about me that is necessary for the purpose requested. I am aware that if I request information be released to an insurance company, necessary information typically includes diagnosis, date and length of service, and what type of service was provided, and in some cases treatment goals and progress toward goals. I understand that this information will become part of the insurance company's files. If I request a copy of any report submitted by the office, it will be provided to me.

PLEASE INITIAL: _____

I have read and/or received a copy of the Privacy Notice, and I understand the information and/or have had all my questions answered. I am aware that I can request a written copy of the Privacy Notice at any time.

Patient/Guardian's Signature: _____ Date: _____

These policies and procedures remain in effect unless Dr. Meade's office makes a change or I request a change with 30 day notice.

Patient/Guardian's Signature: _____ Date: _____

(Revised 3/22/2019)