Nancy S. Thompson, Ph.D., PLLC
3350 Americana Terrace
Suite 320
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Phone: 208-841-1174

Financial Policy

Professional services for your initial session/diagnostic interview will be billed at the rate of $240.00. All subsequent session will be billed at the rate of $2000.00. However, if I am a "preferred provider" (a.k.a. "in network provider") for your insurance plan, I will abide by their contracted rates and submit claims to your primary insurance company on your behalf. If I am not contracting with your insurance plan, you are responsible for the full amount of the session, and I will provide you with a statement of services to submit to your insurance company for reimbursement directly to you. **Self-pay rates may vary**.

Payment is due at the time of service and can be made by cash or check. You are personally responsible for your entire bill regardless of any amount that may be covered by your insurance or by a third-party payer. Please contact your insurance company to confirm your "outpatient mental health" benefits. However, information obtained is a contract description only and not a guarantee of payment. You should be aware that in order for insurance companies to pay a portion of your fees, they require a clinical diagnosis and may request additional clinical information such as treatment plans or summaries.

If there is no payment on your account for 60 days, I consider your account "past due." It is my intention to help you avoid stress related to past due accounts and I will work with you regarding payment options if needed. Accounts "past due" 60 days may be sent to collections. There will be a **$50.00 charge** for any check returned due to insufficient funds.

Insurance Assignment: I hereby authorize my "in network" insurance benefits be paid directly to Nancy S. Thompson, Ph.D., PLLC. I further authorize Nancy S. Thompson, Ph.D., PLLC to release information required to process claims for my services.

Cancellation Policy: ***There is a charge of half the session rate ($90) for any missed appointment or an appointment not cancelled by noon of the previous day.*** Your insurance company will not pay for missed appointments.

I have read and agree to the financial policy in full.

Signature:_____ Date:_____

Confidentiality

State law and professional ethics require therapists to maintain confidentiality, except in the following situations:

1. Suspected child abuse, elder abuse, or dependent adult abuse.

2. "Tarasoff" situations in which serious threat to a reasonably well-defined individual is communicated to the therapist.

3. When threat to injure or kill oneself is communicated to the therapist.

4. If you are required to sign a release of confidential information by your medical insurance.

5. If you are required to sign a release for psychotherapy records related to litigation or other matters with private or public agencies. Think carefully and consult an attorney before you sign away your rights.

6. Patients seen in couple, family, and group work are legally obligated to respect the confidentiality of others. The therapist will exercise discretion, but cannot promise absolute confidentiality, when disclosing information to others involved in your treatment.

7. I may, at times, speak with professional colleagues about our work without asking permission, but all identities will be disguised.

8. My billing manager has access to identifying information but is legally bound by confidentiality.

9. Patients under age 18 do not have full confidentiality from their parents.

10. If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if

possible, and do my best to handle any objections you may have with what I am prepared to discuss. I will also provide them with a verbal summary of your treatment when it is complete.

It is also important to be aware of other potential limits to confidentiality including the following:

- All records, notes on sessions, and phone calls may be subject to court subpoena under certain circumstances. Most records are stored in locked files, but some are in secured electronic devices
- Cell phone, fax, and e-mail are used on some occasions.
- All electronic communication compromises confidentiality

Termination of Treatment

The therapist may terminate treatment if payment is not timely, if agreed upon terms of treatment are not kept (i.e., not seeking required consultations, not keeping regularly scheduled appointments), or if some problem emerges that is not within the scope of competence of the therapist. Usual termination of on-going treatment is two to three sessions. References and/or referral sources will be provided upon termination.

I have read and understand the above policies.

Signature:_____ Date:_____

Signature of Legal Guardian: _____ Date: _____