

## **PATIENT INFORMATION AND OFFICE POLICY STATEMENT PP**

**WELCOME!** Thank you for choosing the Office of Tracie Morrison Salmon, LPC, PA. I would like to take this opportunity to acquaint you with information relevant to treatment, confidentiality and office policies. I will answer any questions you have regarding any of these policies.

**AIMS AND GOALS:** The major goal is to help you identify and cope more effectively with problems in daily living, and to deal with inner conflicts which may disrupt your ability to function effectively. You are expected to play an active role in your treatment, including working with me to outline your treatment goals and assess your progress. Remember your progress depends on what you do between sessions, as well as what happens in your session.

**CONFIDENTIALITY AND PRIVACY:** Issues discussed in your visits are important and are generally legally protected as both confidential and privileged. However, there are limits and guidelines. They are described in detail in the attached "Notice of Privacy Policies and Practices."

**APPOINTMENTS:** Sessions are typically scheduled for 60 minutes, though I do anywhere from 1-2 hour appointments. I encourage 90-120 minute sessions for family or couples therapy because these matters usually need more time at one sitting. Patients are generally seen weekly or more/less as it is deemed necessary for quality care. You may discontinue treatment at any time, but please discuss any decisions with me.

**EMERGENCIES:** In the event of an emergency, you may reach me at (214) 535-5354. If you are unable to reach me, please call your primary care doctor or the local emergency room.

**RECORD KEEPING:** A clinical chart is maintained describing your condition, treatment, and progress, along with dates of and fees for sessions. All active and inactive charts are kept on site, and in a locked cabinet.

**FINANCIAL POLICY AND AGREEMENT:** Payment is due at the time of the session. Your fee per one hour session is \$150.00. I accept cash, check, and credit cards (if a credit card is used, a \$5 transaction fee will be charged). Fees will automatically be billed to your credit/debit card if not paid during session. There is a \$25.00 fee for returned checks.

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Your signature

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date

Continued...

*[If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge \$300.00 per hour for preparation and door to door attendance at any legal proceeding. These will be your full responsibility.] Please fill in the "Pre-Authorized Healthcare Form".*

**HEALTH AND SAFETY:** *I understand that this office is doing all that it can to follow safe guidelines for health relating to COVID-19 and any other illnesses, and I will do my part also. I will not hold Tracie Morrison Salmon, LPC, PA responsible if I become ill.*

**YOUR PAYMENT IS TO BE PAID IN FULL AT THE TIME OF EACH SESSION. FEES ARE SUBJECT TO CHANGE EVERY SIX MONTHS.**

**MISSED APPOINTMENTS AND CANCELLATION POLICY:** *Your visit has been reserved for you. It is your responsibility to be aware of your appointment date and time, and to show up on time for your appointment. I recommend that you show up early for your appointment and anticipate for traffic, bad weather, etc. Arriving late for an appointment might not give you enough time to address all of your issues. If you are unable to keep a scheduled appointment, you may leave messages 24 hours per day at (214) 535-5354. Please notify me as soon as you know you must miss a scheduled appointment or you will be billed/charged at the full rate of \$150.00 for all sessions that were not cancelled with at least a 24 hour notice. I am always willing to do a Tele-therapy session in lieu of an office visit if for any reason you are not able to make your appointment. Just please let me know by texting me before the scheduled appointment. Please fill out the "Pre-Authorized Health Care Form."*

**STATEMENT OF UNDERSTANDING:**

*I have read and understand this information sheet and office policy statement and have had my questions answered to my satisfaction. I accept, and agree to abide by them. I understand that I may withdraw from treatment at any time with notice.*

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*Signature*

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*Date*

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*Parent of Guardian (if required)*