Michael DiBiasie, Ph.D.
101 A Wind Haven Drive
Suite 202
Nicholasville, KY 40356
859-536-2015

Licensed Psychologist
Adult and Adolescent
Mood, Anxiety and
Addiction Disorders

## Fees, Payment, and Cancellation Policy

This office would like to provide you with clear information on our financial procedures and policies. Please discuss any concerns or questions with us.

| CPT code # | Description | Fee |
|---|---|---|
| 90791 | Diagnostic interview | 125.00 |
| 90847 | Individual psychotherapy: 55 minutes | 120.00 |
| 90834 | Individual psychotherapy: 45 minutes | 110.00 |
| 90847 | Family psychotherapy | 120.00 |
| 96101 | Psychological testing: per hour | 120.00 |
| | Private pay per hour | 75.00 |

After hours call may be accepted. There is no charge for a phone call that lasts ten minutes or less. For telephone consultations that require more than ten minutes, our office charges thirty dollars for each fifteen minute increment or any part of a fifteen minute increment in excess of the initial ten minute period. These fees are due and payable when they are incurred, but must be paid by the time of your next scheduled visit; insurance does not ordinarily pay for telephone consultations. There may be times when you want your counselor to read documents that will help with understanding you. If reading such documents requires extensive time, your counselor will bill you for that time, fees that your insurance company will not pay.

Other charges may apply: If you, or someone else (for example, another counselor or your lawyer), needs a copy of your file or of other records that be legally necessary, our

office charges a reasonable fee for copying, plus postage. If your office is required to provide a verbal report, for example by telephone to your physician or attorney, a ten minute consultation will not be charged. If the consultation exceeds ten minutes, our office will charge thirty dollars for

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each fifteen minute increment of consultation. If our office must produce a written report, the same fee will be billed for the time spent reviewing your file and drafting and publishing the report.

If court testimony or deposition testimony is required, a fee of $ 120.00 per hour, plus transportation costs and preparation time will be assessed. This fee must be paid in advance of the court appearance or deposition.

**Cancellation**: Due to the nature of this practice, a specific appointment time has been reserved for you. This appointment MUST BE CANCELLED ATLEAST 24 HOURS IN ADVANCE to avoid being charged for the session. You will be responsible for charges incurred due to late cancellations of failing to keep your appointment. Future appointments may not be scheduled until these charges are paid.

**Insurance:** Your medical insurance may not cover professional fees for your visit. This practice is willing to submit claims on your behalf to your insurance company. On the day of your appointment, it is YOUR responsibility to pay any deductible, copay, co-insurance, or any other balance that will not be paid by your insurance company. If you have secondary insurance, it is your responsibility to file claims with them. Your therapist will provide you a receipt for this.

- I authorize use of this form on all my insurance submissions.
- I authorize the release of requested information to my insurance company.
- I authorize direct payment by my inaurance company to Michael DiBiasie, Ph.D.

- I authorize a copy of this signed form to be used in place of an original copy.
- I understand that I am responsible to pay all charges not covered by my insurance company.

Printed name of client: _____

Signature of responsible party: _____

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## Electronic mail/Internet Confidentiality / Voicemail Disclaimers

### E-mail notice

It is important to be aware that e-mail communication can be relatively easily accessed by unauthorized people, and therefore can compromise the privacy and confidentiality of such communication. E-mails in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Un-encrypted e-mails are even more vulnerable to unauthorized access. Please do not use e-mails for emergencies. While I check my phone messages frequently during the day when I am in town, I do not always check my e-mails daily.

### Internet Confidentiality

The internet is not a totally secure medium for purposes of transmitting counselor-client or other privileged information. Professional advice will not normally be provided via the internet. Any inquiry or contact with our website or office via the internet should not be considered a substitute for telephonic, written, or in-person communication. If you send messages by e-mail or other electronic forms of transmission, you acknowledge and agree that you may be compromising confidentiality by using such means of communication. Clients with professional inquiries are urged to contact our office.

### Voicemail Disclaimers

It is important to be aware that voicemail messages, whether or not linked to servers such as i-cloud, may be accessed by unauthorized people, and therefore can compromise the privacy and confidentiality of such communication. Please do not use voicemail for emergencies. In a matter of grave consequence, for example, suicide, please go to your nearest hospital emergency room. This office makes it a standard and customary practice to check voicemails frequently. Every attempt will be made to return calls as soon as practical.

I have read these three disclaimers and have had an opportunity to discuss them with my treating therapist, Dr. Michael DiBiasie.

If I choose to use e-mail, internet, or voicemail services to communicate with Dr. DiBiasie, I do so understanding and accepting the risks as defined above.

_____ _____

Client signature Date

_____ _____

Witness signature Date

**Michael DiBiasie, Ph.D.**

**101 A Wind Haven Drive**

**Nicholasville, KY 40356**

## Informed Consent to Receive Psychological Services

Welcome to Michael DiBiasie, Ph.D., Center for Relationships, mental health services. Our goal is to provide you with quality mental health care. Your informed participation and your understanding of payment arrangements are essential to our effort to help you, as well as to your effort to benefit from our time together. The following statements describe our agreement regarding the services that we will provide you.

I, _____, give my consent to receiving psychological services from Michael DiBiasie, Ph.D.. I understand treatment will involve:

- My explanation of the problem and the change I desire to make.
- A new perspective offered by my therapist on the problem(s) I have identified.
- Dialog regarding possible solutions.

I am voluntarily and freely making this decision to receive this treatment.

I understand that there are certain risks associated with receiving these services, including but not limited to, increased distress and increased anxiety or depression. I also understand that there are possible benefits with these services, including:

- Increase peace of mind.
- Desired changes in my behavior.

Reasonable alternatives or additions to this therapy have been explained to me including:

- The prescribed use of psychotropic medication as directed by a physician.

- Seeking counsel of another person, e.g., my pastor, friend.
- Choosing to do nothing or to simply wait for change to occur spontaneously.

I understand that I have the right to ask questions about my treatment at any time. At this time all my questions regarding receiving psychological services have been answered to my satisfaction. I am authorizing my therapists, Michael DiBiasie, Ph.D. to perform these services.

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I understand that my participation is voluntary. I understand that regular attendance will enhance the opportunity for improved outcome and that I may withdraw from treatment at any time, in according with the policy for doing so.

I have read this form fully and completely. I have had the opportunity to discuss with my therapist all aspects of treatment, have had my questions answered, and understand the treatment that is planned. I understand there are no guarantees stated or implied and that I am accepting the risks inherent in the course of receiving psychological services. My signature below acknowledges my understanding and agreement to the information stated above. I grant Michael DiBiasie, Ph.D. permission to perform the professional procedures deemed appropriate for my treatment.

_____
_____

Client signature date

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## Client Intake Information

Name: _____ Today's date: _____

Home address: _____ Date of Birth: _____

Zip code: _____ Age: _____

Home phone: _____Cell phone : _____ Work phone: _____

Employer/school: _____

Current medications:
_____

Person to contact in Emergency: _____ Relationship: _____

How did you learn of my services:
_____

Education: _____ Marital status: _____

List others in household:

Name gender date of birth relationship to client

Frequency of alcohol use: _____ Frequency of drug use:

_____

Describe any pending legal issues:

_____

List prior counseling/therapy (date and name of therapist):

What issues do you hope to resolve in therapy at this time:

For patient: How satisfied are you with your life at this time:

_____
_____

## Insured/Responsible Party Information

Full name of insured: _____ Relationship:

_____

Home address: _____ City: _____ Zip code:

_____

Employers/address/phone:

_____

Date of birth of insured: _____

Insured Primary insurance company: _____ ID Number:

_____

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# Limitations on Client Confidentiality

This practitioner is required by law to disclose confidential information if ANY of the following conditions exist:

- You are a danger to yourself or others.
- You seek treatment in order to avoid detection or apprehension or enable anyone to commit a crime.
- Your therapist was appointed by the courts to evaluate you.
- Your contact with your therapist is for the purpose of determining sanity in a criminal proceeding.
- Your contact is for the purpose of establishing competence.
- The contact is one in which your therapist must file a report to a public employer or as to information required to be recorded in a public office, if such report is open to public inspection.
- You are under the age of 18 years and are the victim of a crime.
- You are under the age of 18 years and your therapist reasonably suspects you are the victim of child abuse. Your therapist may also disclose information if you are the victim of emotional abuse.
- You die and the communication is important to decide an issue concerning a deed or conveyance will or other writing executed by you affecting an interest in property.
- You file suit against your therapist for breach of duty or your therapist files suit against you.
- You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.

- You waive rights to privilege or given consent to limited disclosure by your therapist.
- Your insurance company paying for services has the right to review all records.

If you or your child is or becomes a party to a custodial action in Kentucky, it IS VERY LIKELY that relevant confidential information may be disclosed in legal proceedings.

If you have any questions or concerns on the limits of confidentiality, please discuss them with your therapist.

I am consenting to my (my dependent) receiving outpatient evaluation and/or psychotherapy services.

_____
_____

Printed name date

Signature