

Deanna Miesch, LPC, ATR-BC
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OFFICE POLICY

Financial arrangements for professional services are often misunderstood. In order to avoid any confusion it is important to explain the financial policy. Payment for each sixty minute session is \$175.00 and is due at the beginning of each session. You have been provided with a fee schedule. Please read this carefully. If you are utilizing insurance, full payment is expected at the time of service. If you would like to file an insurance claim to utilize out of network benefits, I will provide all necessary information for you to file on your own. A DSM-V Diagnosis is required for all insurance claims. When you sign a release of information, your insurance carrier has privilege to information divulged during therapy and this becomes a part of their medical record affording limited confidentiality.

Cancellations for individuals are often a necessity. There is no charge if the cancellation is made in advance of 24 hours from the appointment time. Otherwise, the full fee is due at the next scheduled appointment. If three appointments are missed without appropriate cancellation, treatment will be terminated. Phone calls beyond 15 minutes are billed directly and are not insurance reimbursable. Please do not arrive more than 15 minutes before your session.

Therapists are often limited in what can be provided. I am not a crisis counselor. If there is an emergency, a number is provided for the crisis hotline is on my voicemail. You may also dial 911 or go to your nearest emergency room. Urgent calls during the week will be returned within 24 hours if possible between 10 am and 7 pm. Non-emergency calls will be returned as promptly as possible. If you request a return call, it is imperative that you leave your phone number and several times during the day when you can be reached. Any case beyond my limits of training will be referred to another professional.

- In the event you are taking medication, please sign a release for communication between myself and your medical professional to insure best possible care.
- Information about my professional background and experience is available to you upon request. Please ask if you have any questions about therapy.
- Active participation in the counseling process is important for progress to be made. Keeping appointments will allow you to take full advantage of therapy. If an emergency arises, please call as soon as possible to reschedule your appointment.

- Deciding when to end therapy is an important part of the process. You are encouraged to discuss this at any time.
- If you are or will be seeking a court appearance, you are encouraged to seek therapy elsewhere. I do not provide parental evaluations. Recommendations for therapists that provide such a service can be provided upon request.
- Clients are welcome to email me regarding scheduling of appointments. Any other issues should be addressed in session.
- Confidentiality of records: In general, all client records are confidential and cannot be released without written consent of parties involved. A few exceptions exist which you should be aware of:

1. Upon suspicion of abuse or neglect of a child or elderly person, records can be divulged to the Department of Human Services.

2. Upon subpoena from a court of law, records must be divulged.

- There is a \$35 service fee for returned checks.

- Fees for services are as follows:

Individual Assessment:

-90 minutes \$262.50

-60 minutes \$175.00

Telephone Consultation (calls less than 5 minutes will not be charged)

-15 minutes \$43.75

-30 minutes \$87.50

-60 minutes \$175.00

Payment in cash or check is subject to a \$5 discount. Payment in credit card is subject to full fee.

I have read and understand the information provided and agree to the conditions outlined.

Signature of Client: _____ Date: _____

Signature of Parent/Guardian (if under 18 years): _____ Date: _____

• Professional Consultation: On occasion, Deanna Miesch, LPC, ATR-BC will seek consultation with other professional colleagues in order to ensure high quality treatment. It is understood that these professionals maintain strict confidentiality using verbal consultation only. I understand and consent to this consultation arrangements.

Signature of Client: _____ Date: _____

Signature of Parent/Guardian (if under 18 years) : _____ Date: _____

CONSENT FOR TREATMENT

I give full consent for the completion of an evaluation and the provision of treatment as necessary until I otherwise notify Deanna Miesch, LPC, ATR-BC.

Client's Signature _____ Date _____

For the treatment of children and dependents:

I certify that I have legal responsibility for _____, including the legal right to initiate mental health treatment on his/her behalf. I give full consent for the completion of an evaluation and the provision of treatment as necessary until I otherwise notify Deanna Miesch, LPC, ATR-BC.

Parent/Guardian's Signature _____ Date _____

