**The Institute for Change**
**(973) 734-0780**

**44 Elm Street**
**2nd Floor**
**Morristown, NJ 07960**

**460 Bloomfield Avenue**
**Suite 211**
**Montclair, NJ 07042**

## PROFESSIONAL POLICIES

Welcome to our practice. We look forward to working with you. Please read this document carefully, since it contains important information about our professional services and business policies. If you have any questions, please feel free to discuss them with us.

**Payment and Billing Procedures**: You are expected to pay for services (full or co-payment as agreed) at the end of each session. If you are covered by health insurance, we can submit claim forms directly upon request. Please make all checks out to The Institute for Change.

**Cancellation Policy**: Appointments cancelled with less than 24 hours notice will result in a charge reflective of your fee, unless you are cancelling due to illness or emergency. You insurance company does not reimburse charges for missed appointments or late cancellations, so you will be responsible for payment of the session. We appreciate your courtesy in providing us with as much notice as possible if cancelling or rescheduling an appointment.

**Confidentiality:** Information shared between a patient and a psychotherapist is confidential and protected by law. Information cannot be disclosed without permission in writing from you or your parent/legal guardian if you are a minor. The exceptions to this rule are as follows:

1. The therapist receives information suggesting that child abuse may have been committed. State law requires notification to the Division of Youth and Family Services.

2. The therapist receives information suggesting that the client presents a danger to self or others.

3. Information in the therapist's file is subpoenaed and a judge upholds the subpoena.

4. Information is requested b your insurance company to authorize reimbursement. In this case we provide only what is allowed by law, usually name and address, CPT code (type of service provided), date of service, fee and diagnosis.

Thank you for following our practice guidelines. We look forward to working with you.
You may either print and bring your signed form to your first appointment, or, we can provide the form to you at our office.

By signing below, I acknowledge that I have read and understood the above policies, and agree to follow them. It will also serve as my consent to receive treatment, or, if the client is a minor child to authorize treatment for that child.

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Signature of Patient Date

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Signature of Parent/Legal Guardian Date