McCaskill Family Services, PLLC

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734-416-9098, Ext. 1 – www.mccaskillfamilyservices.com
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POLICIES REGARDING PROFESSIONAL SERVICES AND GROUP THERAPY

CONFIDENTIALITY Any information you provide, as well as counseling records that are maintained, are kept strictly confidential, with the exception of life threatening situations, cases of suspected child abuse, when release is otherwise required by law, or when you request that the information be released. Should the need arise, your case may be discussed anonymously during case consultation with another licensed psychologist while keeping identifying information strictly confidential. Clients participating in group therapy are politely asked to keep group information confidential to the best of their ability; however, participants understand that other clients in the group are not licensed mental health providers and are not held to the same strict levels of confidentiality.

PAYMENT OF FEES All clients are required to pay a fee of $175.00 to hold a spot for group therapy. Each week $175.00 will be charged to the card we have on file. The charges will show up as MFS on a credit card statement, and clients will still receive their normal statement from MFS in the patient portal each week to use for reimbursement.

INSURANCE Many insurance plans cover all or part of the costs of psychological services. If you expect to file for reimbursement from your insurance company, a receipt will be available in your patient portal each week**.** Submission of forms or receipts to the insurance company is, in all cases, the client's responsibility.

MISSED SESSIONS There will be no reimbursement for missed sessions during the eight-week groups. However, there will be a 90-minute make-up group time at the conclusion of the 8 week session available for any missed sessions at no additional cost. Alternatively, if the client would like to schedule an individual make-up session at any time, he or she may do so at a charge of $175.00/45 minutes.

Please indicate that you have read the above statements by signing below. I give consent for myself or my child to be seen professionally by McCaskill Family Services.

Client Signature: _____ Parent Signature: _____

Client Name (Printed): _____ Parent Name (Printed) _____

Date: _____ Date: _____

SS#: _____