



**Welcome, and thank you for choosing Intermissions Therapies, LTD.**

We appreciate and respect your confidence in coming to us and we will work hard to maintain your trust. The following information is meant to familiarize you with our policies concerning confidentiality, appointment scheduling, payment of fees, and insurance billing.

**Confidentiality:** All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. The Notice of Privacy Practices is made available for you in the waiting room to review or take a copy. The notice describes how information about you may be used. I acknowledge that the Notice of Privacy Practices was made available to me. **Initial here** \_\_\_\_\_

**Apoinments:** Appointments are made between you and your therapist. Your next appt. date is written on your superbill. Our office number is 630-232-7770 and a message can be left directly in your therapist's voice mail if you need to reschedule or cancel an appointment. We do charge for appointments canceled less than 24 hours in advance. These visits can not be filed with your insurance company and will be due by the patient. The fee for a missed session will be \$100.00. **Initial here** \_\_\_\_\_

**Payments and Insurance Billing:** The fee for psychotherapy varies by individual therapist. Payment for each session is required at the time of each session. Payment may be made by cash or check written out to Intermission Therapies. The office charges a \$25.00 return check fee for any checks returned to our office by our bank. **Initial here** \_\_\_\_\_

It is your responsibility to contact your insurance company prior to your first appointment to request authorization for services and verification of benefits. Intermissions will file claims with your insurance company provided we are given sufficient information to do so. Please note it is your responsibility to verify specifics of your coverage and failure to do so may result in loss of benefits and you being responsible for the outstanding balance. All copays and coinsurance are due at time of session. If benefits are maxed out you will be charged your therapist's session fee. **Initial here** \_\_\_\_\_

Please feel free to contact us with any questions regarding these policies.

Thank you

The Intermission Therapies Staff

I have read and understand these policies.  
(signature and date) \_\_\_\_\_