



Joanne Gutzwiller, Ph.D.
Child Psychology Services

2810 Mack Road, Fairfield, OH 45014-5130. (513) 874-4530

CONTRACT AND GENERAL INFORMATION

Thank you for your interest in my services. The following important information will help us work together effectively and respectfully.

Appointments

Appointments generally last for 45 to 50 minutes. If you need to cancel an appointment, please call the office at least 24 hours prior to your appointment time. Monday appointments must be cancelled by noon of the previous Friday. The receptionist is available to take calls Monday through Friday, 7:30 a.m. until 3:30 p.m. In addition, our answering service allows you to leave confidential messages 24 hours a day. Missed therapy appointments, not cancelled at least 24 hours prior to an appointment time, incur a charge of \$90. Missed testing sessions, not cancelled 24 hours prior to appointment time, incur a charge of \$90 per hour of testing scheduled. These charges are not covered by insurance.

Emergencies

If you have an emergency (your health or safety or that of a family member is at risk), or your call is urgent (cannot wait until morning) and the receptionist is not available, please listen to my voicemail message for an emergency contact number. Your call will be returned within an hour. The first ten minutes per week of after hours contact with you or your child is free of charge. After 10 minutes, the hourly charge is \$160, prorated (example: a 15 minute call is \$40). In situations when it is not possible to wait for a return phone call, please call 911 or go to a hospital emergency room.

Fees

The fee structure is as follows:

- Initial Consultation \$175 per 50 minute session
- Individual Psychotherapy \$140 per 45-50 minute session
- Family Therapy \$175 per 45-50 minute session
- Psychological Testing..... \$175 per 45-50 minute session
- After Hours Emergency Contact \$175 per hour after first (free) 10 minutes
- Billable Professional Time..... \$175 per hour
(treatment summaries, test scoring and interpretation, reports, letters on your behalf)

Insurance

Dr. Gutzwiller is an in-network provider on a few insurance panels only. It is your responsibility to be familiar with your insurance coverage and your portion of fees (deductibles and co-payments). ***If your insurance/managed care company requires a referral or preauthorization for services, and you are here without one, or if you are seeking services from an out-of-network provider, your insurance/managed care company may deny benefit payments. In that case, you will be responsible for payment of these services.*** Please read your subscriber’s manual and call your insurance company if you have questions.



Billing

Insurance co-payments, deductibles, and session fees (if you are not using insurance or are using out-of-network benefits) are due at the time of service and can be paid in cash, by check, or by credit card. There will be a fee of \$25 for any returned check. As a service to our patients, we will file your claim with your insurance company if we are a participating in-network provider. However, if payment is not received within 60 days of the claim, you will be responsible for the bill. Please note that a collection agency is used for bills over 120 days past due. The collection agency fees and/or legal fees are charged directly to the patient's delinquent account. In addition, it is important to know that the collection agency may release information related to unpaid balances to third parties including attorneys and national credit reporting agencies.

Missed Appointments

Your appointment time is reserved for you and it is rarely possible to reschedule that appointment time without a 24 hour notice. Therefore, a fee of \$90 is charged for missed therapy appointments not cancelled at least 24 hours prior to the appointment time. For testing sessions, a fee of \$90 is charged per hour of testing scheduled if the appointment is not cancelled at least 24 hours prior to the appointment time. Insurance cannot be billed for missed appointments.

Confidentiality

Your signature below allows me to provide assessment and/or treatment to you or your child (or other dependent) and also indicates that you have read and understood the following information about confidentiality. In addition to the information summarized here, please see the HIPPA Notice form in the office waiting room. You will also be provided with the HIPPA form at your first appointment. It is important to understand that the privacy and confidentiality of our conversations and records is a privilege of yours and is protected by the HIPPA law and ethical standards. There are a few important exceptions to this privilege:

1. I am required by law to report suspicion of imminent danger to yourself or others.
2. I am required by law to report evidence of child abuse or elder abuse.
- 3. I am required to disclose confidential information, including patient diagnoses, to insurance companies when applying for treatment authorization or insurance reimbursement. Please take this fact seriously. If we will be dealing with any material you wish to keep private, you may want to consider paying "out of pocket" for the service rather than using your insurance benefits. Involvement of a third party payor means they have access to your records.**
4. If a court of law subpoenas my records, I may be required to provide the information specified.
5. Parents have a right to know about psychological services provided to their minor children.
6. During my extended absences, I often ask a trusted colleague to be available for emergency calls. It may be necessary to update this colleague about your situation so that any emergency may be properly managed in my absence. Such colleagues are also obligated to maintain confidentiality as set forth by this document.
7. In addition, I employ an office manager with whom I share protected health information for administrative purposes such as scheduling, billing, and quality assurance. The office manager has been trained to protect patient privacy and confidentiality and has agreed not to release any information outside of the practice without my permission.
8. In the unlikely event that a bill is 120 days past due, personal information about you will be sent to a



collection agency.

Contract

I hereby authorize Joanne Gutzwiller, Ph.D. to render assessment and/or treatment to me, my dependent, or person for whom I serve as legal guardian. I have read the preceding policies and information sheet and I understand the limits of confidentiality as stated above. I assume personal financial responsibility for all assessment and/or treatment services conducted by Dr. Gutzwiller per the terms of this contract. Such responsibility is not transferable to any other person even in the case of custody or child support disputes and/or related court decrees.

Signature of Patient, Parent, or Legal Guardian

Date