Andrea Jacobson, M.D., Ph.D.

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Office Policies and Agreement- please read carefully.

1. Dr. Jacobson agrees, as a courtesy to me, to bill my insurance. To allow her to do this, I agree to the release of any information required to process insurance claims. And I authorize my insurance benefits to be paid directly to Dr. Jacobson. I understand that I am financially responsible for non-covered services (services my insurance company may choose not to pay for, such as family meetings, time spent coordinating care with other doctors or family members, prolonged sessions, prolonged telephone calls, completion of forms, etc).

2. I agree to pay promptly any charges not covered by insurance. If this becomes a financial burden, I will discuss this with Dr. Jacobson to see whether or not a special payment plan can be arranged

3. I understand that my appointments are reserved specifically for me. I agree to notify Dr. Jacobson at least two business days in advance if I am not going to attend a session. I understand that Dr. Jacobson will bill her regular rate for a missed session if this notice is not given. I also understand that insurance will typically not cover any part of the charge for a missed session, and I would have to pay the whole charge myself.

4. Dr. Jacobson may, at her discretion, choose to waive all or part of her fee for a late cancellation or missed session if an unforeseeable circumstance prohibited my attending a session. I will tell Dr. Jacobson if I believe this to be the case.

5. Dr. Jacobson will bill for time spent on extended phone conversations between sessions, medication refills between sessions, or extensive paper work.

6. In the event it should become necessary to place for collection an unpaid balance due for services rendered, I agree to pay collection fees, and should legal action be filed, reasonable attorney fees, filing fees, and any other costs the court determines proper.

7. I understand that the outcome of psychiatric treatment cannot be guaranteed. If I am not satisfied with my treatment, I will discuss this with Dr. Jacobson. I understand that I always have the option of getting a second opinion or changing my treatment to another psychiatrist or other mental health professional.

8. I have read and understood these policies. I have had an opportunity to ask questions about them. I have been offered a copy of these policies.

Signed_____Date_____