David Saavedra, LCSW, CEAP
Practicante Independiente
4800 N lOth, Suite D
McAllen, TX 78504

POLIZA I)E CANCELACIfON

Por favor tome en cuenta Que si usted no hace la cancelaci6n de su cita, o no se presenta a ella, no me es posible dar atenci6n a otros clientes. Le agradezco Que considere Que mi pratica de psicoterapia es muy distinta a la de un medico, quien en el transcurso de una hora puede atender a muchos pacientes. Por esta raz6n, si usted no asiste a su cita o no cancela con 24 horas de anticipaci6n, ser usted responsable de pagar el costo total de la sesi6n. Se le har el cargo a su tarjeta. En caso de contar con seguro medico, deber pagar s6lo el monto Que la compa6fa me reembolsa.

Es importante hacer de su conocimiento Que las compai::ffas de seguros no cubren cancelaciones tardias ni citas a las Que usted no se presente. Esta polftica de la empresa aplica tambi6n a sesiones EAP (Employee Assistance Program) Programa de Asistencia al Empleado) Que es un beneficio gratuito para el trabajador.

Es necesario que usted cuente con tarjeta de credito o d6bito cuyos datos seran archivados para asf poder cubrir el cargo de posibles cancelaciones tardfas o inasistencias a Sus citas.

Agradezco su amable consideraci6n sobre este importante asunto.

Firma del Cliente

Fecha (dia / mes / a6o)

Firma del padre o tutor del menor

David Saavedra, LCSW
Independent Practitioner
4800 N laths Suite D
McAllen, TX 78504

CANCELLATION POLICY

If you fail to cancel a scheduled appointment or you do not keep your appointment, I cannot use this time for another client. Please take into consideration that my psychotherapy practice is very different than a medical doctor who can see numerous patients in an hour. You will be billed for the entire cost of your missed appointment. A missed appointment with less than a 24 hour notice or no shows will be payable by the client. For those clients with insurance, your responsibility is to pay what the insurance reimburses me. Insurance companies do not cover no-shows or cancellations. This policy also applies to EAP sessions that are a free benefit to employees. You will need to have a credit card or debit card on file with me to cover potential no shows or late cancellations.

Thank you for your consideration regarding this important matter.

Signature of Client Date
Signature of guardian if minor

The Marriage & Family Wellness Center
Independent Practitioner
David Saavedra, LCSW,
956-668-1488 Voicemail
4800 N lOth, Suite D
McAllen, TX 78504

Therapy Process, Office Procedure and Financial Agreement

Please read and sign TWO copies. Keep one for your records.

The Marriage & Family Wellness Center (TMFWC) is a business office where a number of mental health professionals practice.

Therapy Process, Rights and Risks

- Please feel free to ask questions about any aspect of the therapy process.
- If you have been referred by a court or state agency, you should know that during the therapy sessions, you have the right to divulge only what you want to be included in a report.
- To have effective therapy sessions, you need to be willing to discuss what troubles you and be open to change.
- During therapy sessions, you may remember unpleasant events, have intense emotions aroused, and/or you

Office Procedures

Appointments:

- All office visits are by appointment and will be scheduled through me directly. Please arrive on time, as you use your own time when you arrive late for an appointment. The usual length of an appointment is 50-60 minutes.
- LATE CANCELLATIONS (LESS THAN 24 HOURS BEFORE) AND/OR NO-SHOW APPOINTMENTS ARE BILLED TO THE CLIENT FOR THE FULL AMOUNT. IF YOU ARE PAYING FOR SERVICES WITH YOUR INSURANCE OR EAP BENEFITS/ A NO SHOW OR LATE CANCELLATION WILL BE CHARGED EQUAL TO WHAT THE INSURANCE/EAP REIMBURSES ME.

LATE CANCELLATION CHARGES.

In the case of illness, please notify me no later than 9:OOAM the day of the appointment. Please leave a voice mail message at 956-345-544. (TMFWC does not employ secretarial/receptionist support services.) If your appointment is cancel/ed or missed, you should contact me for a new appointment time.

Insurance Billing

The client portion (co-pay) of fees is expected at the time of service. I will bill your insurance company for services provided. Ultimately, you are responsible for payment on your account. If your policy requires pre-authorization to receive services, this is your responsibility and needs to be handled prior to your first visit. You may also need to check with your insurance provider whether you have a deductible to meet.

Failure to pay your part may jeopardize your benefits. Co-pays are not negotiable. Clients paying on a cash basis are expected to pay in full at time of service.

Phone calls in excess of (5) minutes will be billed at the usual rate. Insurance does not cover phone consultations, and therefore, the client assumes financial responsibility for such phone consultations.

You should discuss any change in your financial situation with me. In the event you find it necessary to change mental health providers and require records to be sent from TMFWC, your account will need to be paid in full.

My Customary Fees

Initial Consultation: $125
Individual Psychotherapy: $95
Couples Psychotherapy: $125
Family Psychotherapy: $125
Clinical Hypnosis: $150.00
Immigration Evaluations: $300
Substance Abuse Evaluations (DOT): $450
Court Testimony: $250/hour, including travel time, **portal to portal**
Letters/Treatment Reports: $25 to $75
Bounced checks: $25

Financial Agreement with TMFWC

I have read, understand and agree to the above office and payment policies. I have discussed these policies with my therapist (if desired) and all questions have been answered to my satisfaction. I have been offered a copy of these policies to take with me.
I hereby authorize TMFWC and my therapist to release to my insurance company any information acquired in the course of my therapy (if client is a minor, or parent or guardian sign)
1 understand my insurance coverage is a relationship between the insurance company and myself, and I agree to accept responsibility for payment of charges incurred.

Consent **to Treatment and** Fees

I hereby agree to full responsibility for all expenses incurred by or on account of this client and hereby assign TMFWC and all insurance benefits due to me to the full extent of my financial obligation to TMFWC. I have read and/or received a copy of the TMFWC Privacy Policy.

Client(s) Signature(s) Date

Emergencies

In case of an emergency, the best phone number to use is 956-345-5444. If you receive the voice mail, please leave a message. I may be on the phone, in therapy with someone else, or may be out of the office.

In a crisis situation, if I cannot be reached by you may call the 24-hour Mental Health Crisis Line: 877-289-7199, or go immediately to your local hospital emergency room.

Effective: July 7, 2019