Shulamit Glaubach, M.D._____
1939 Divisadero Street
Suite 4C
San Francisco, CA 94115
(415) 440-6505

Office Policy for Psychiatric Evaluation

Appointments are $550 and are of 45 minutes duration. Payment/co-payment is due at time of service, including any deductible due. It is my responsible to know my co-pay, deductible, and my standing with my deductible.

1. **I agree to ~4-6 evaluation sessions for the purpose of developing a treatment plan. Ongoing treatment regularity will be agreed upon.**
2. **Health insurances companies may require records from Dr Glaubach in order to determine that the treatment is "medically necessary". For this purpose I hereby authorize Dr Glaubach to release any or all medical information about me, including psychotherapy notes to my health insurance provider. You may need to sign an additional release form. There is no time limit to this authorization unless it is revoked by me in writing. I understand that I have a right to a copy of this document upon request.**
3. **I authorize payment of medical benefits directly to Dr Glaubach.**
4. **Once appointments are scheduled, I am aware that two business days advance notice is required to make changes to the above mentioned evaluation plan. Changes to agreed schedule will be discussed during appointment times.**
5. **Upon signing this agreement, I will provide credit card, voided check, and an authorizing signature which will be used to pay for any late cancellations or no-shows. If I need to reschedule an appointment, Dr Glaubach will do her best to accommodate me, however I am aware I am still responsible for payment if an alternate time is not found for that week.**
6. **Missed appointments cannot be billed through insurance. I am responsible for FULL fee of missed or cancelled appointments, i.e. $550 per session.**
7. **Time preparing reports and letters is charged on a prorated basis at the same rate.**
8. **Phone call time spent talking to me or collateral persons such as pediatricians, teachers, and counselors, etc. will be billed on a prorated basis for any calls lasting in excess of 5 minutes. Any expenses incurred for long distance phone calls and copies of medical records are charged to my account.**
9. **Once in ongoing treatment, two weeks advance notice is required for cancellations due to vacation (please see ongoing treatment policy).**
10. **Should I choose to terminate care, I will allow (or allow my child) at least two weeks′ worth of sessions for wrapping up the treatment and to say goodbye.**
11. **All negotiations with and payments to my insurance company are my sole responsibility.**
12. **Any fees waived by Dr Glaubach will be on the condition that remainder of the balance will be paid in full. I am aware that Dr Glaubach retains the right to collect payment via credit card, ACH transfer, and, as a last effort, engage small claims court proceedings in the case of unpaid bills.**

13. **I acknowledge that Dr Glaubach does not accept the responsibility for collecting an insurance claim or for negotiating a disputed claim. Insurance reimbursement is a contract between myself and the insurance carrier. I am solely responsible for the payment.***
14. **A 1% interest per month will be collected on any unpaid balance. Additional reasonable administrative fees may be incurred as well. Should the account be taken to small claims court, the undersigned shall pay all reasonable collection expenses, interest on the unpaid balance at 1% per month from the date of service, and/or reasonable administrative fees and attorney fees, as well as, court costs.**
15. **In cases of separation or divorce, the undersigned is responsible for payment unless other written arrangements are made with Dr Glaubach.**

I have read this policy and understand that, regardless of any insurance coverage I may have, I am responsible for payment of my account within the usual limits of this Office Policy.

Name of Patient: _____ DOB:_____
Address: _____
City:_____ State:_____ Zip Code:_____
Phone number: _____

Emergency Contact
Name: _____ Phone #:_____
Relation to Patient: _____

School/Work: _____ Phone #:_____

Pediatrician or Primary Care Provider:_____
Phone#:_____ Fax#:_____

Party Responsible for Payment:_____

_____ _____
Signature ***Date***

Social Security #:_____
Name on Credit Card: _____ Checking Account:_____
Credit Card #: _____ Routing #: _____
Security Code: _____ Credit Card Zip Code: _____
Expiration date: _____

PLEASE WRITE LEGIBLY

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* Insurance will not cover calls to contact other medical representatives, review of records, and any other correspondence pertaining to my treatment plan.