

**Maria T. Aranda, Ph.D.**  
**Licensed Psychologist #PY5983**

**Scheduling and Billing Policies**  
**New Patients**  
**Effective January 2011**

This form serves to outline my general office policies. **Please read it carefully as it contains important information.** I will provide you with a copy to retain for future reference.

**SCHEDULING:** Psychotherapy services are provided on a regular schedule, weekly in most cases, unless therapeutic needs dictate a more or less frequent schedule. I request as much advance notice as possible in order to fill your appointment if you are unable to make it. **You are responsible for the fee for the session if less than 48 hours notice is given.** You can leave a message on my voicemail at any time, 24 hours a day. **I reserve the right to terminate services after two missed appointments (less than 24-hour notice).**

**CONFIDENTIALITY:** Psychological services are confidential as provided by Federal and Florida laws. I comply with all regulations regarding the privacy of psychological information and comply with the HIPAA law. I will provide you with a separate form regarding privacy policies as required by HIPAA.

**WORKING WITH MINORS:** Treatment of minors is a collaborative process and open lines of communication with parents and guardians help move the pace of treatment along. In the case of divorce or separation, it is also important that all individuals who have custody provide consent for treatment in writing. Treatment or evaluation cannot commence without said consent.

**CLINICAL EMERGENCIES:** I check my messages regularly Monday through Friday between 8 AM and 5PM. I make all efforts to respond to crises and emergencies as promptly as possible. **If an emergency is life-threatening and requires immediate attention that I am unable to provide, assistance can be sought from the nearest hospital emergency room or by calling 9-1-1. The Crisis Center can also be reached at 2-1-1.** After-hours non-emergency phone calls will be returned during regular office hours.

**FEES AND BILLING/INSURANCE:** I currently am on the provider list for Tricare and Humana insurance plans. I do not use any business associates and perform all billing myself. Although your insurance carrier may pay for claims on your behalf, **all unpaid claims are the member's responsibility.** All co-pays are required at the time of service. When providing information to your insurance, I will only give the required information so as to protect your privacy.

If you decide to not utilize your insurance for payment, the fee for individual psychotherapy is \$175 for an initial consultation and \$150 for subsequent sessions. Sessions are 50 minutes long. I do expect payment for each session to be made at the time of the appointment. Checks should be made out to "Maria T. Aranda, Ph.D." for the amount shown on the bill. If

a large unpaid bill is accrued, I may decide to discontinue treatment until the balance is paid or payment arrangements have been made, as is clinically appropriate. In addition, during instances where a client is refusing to pay for services already rendered, I may involve the use of collection agencies if payment arrangements cannot be agreed upon.

**CHILDREN UNDER 14:** Please remember that I am unable to supervise children in the waiting room once their session is over. For their safety, please come into the waiting room to pick them up (rather than having them wait outside for your car), making sure that you are back at least 10 minutes before the end of the session. This will also provide the opportunity for me to check in with you if an urgent matter came up during the session.

**INCLEMENT WEATHER:** In case of inclement weather, I try to come into the office if at all possible. I will call to notify you if my office is closed. Alternately, you can call my office at 813.431.2798. My outgoing voicemail messages will notify if my office is closed. I do not necessarily close if the public schools or local governments are closed.

**EMAIL:** You are welcome to contact me via email at mariaaranda@tampabay.rr.com. This is a good way to provide me with information outside of a session, such as a specific event that occurred during a week or an update on a child’s behavior. **IMPORTANT** – email is for non-emergency communications and should not be used for scheduling or cancellations. I check email several times a day, depending on my patient schedule. *Cancellations should always be made by telephone.*



**Agreement to pay for services**

I, the client (or person acting for the client), request that Dr. Maria Aranda provide professional services to me or to \_\_\_\_\_, who is my \_\_\_\_\_.

I agree that I am responsible for the charges for services provided by this psychologist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account.

I understand that if my account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, Dr. Aranda has the option of using legal means to secure payment. I understand that this may involve hiring a collection agency or going through small claims court which will require Dr. Aranda to disclose otherwise confidential information. In most collection situations, the only information Dr. Aranda will release regarding a client’s treatment is his/her name, the nature of services provided, and the amount due. My signature on this form represents my agreement and consent to Dr. Aranda’s financial policies.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_

Printed name

I have read and understood the office and financial policies of Maria Aranda, Ph.D. and am in agreement. **My signature below also provides consent for treatment for myself, my child, or an individual for whom I am a legal guardian.** In cases of legal guardianship or custody, I attest that I have provided Dr. Aranda with accurate information about custody or guardianship and that I am able to consent to this treatment.

Name of person providing consent

(parent or guardian if under 18 years of age): \_\_\_\_\_

Signature of person providing consent: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's name: \_\_\_\_\_

Patient's date of birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone(s): \_\_\_\_\_

Cell Phones: \_\_\_\_\_

Emergency contact: \_\_\_\_\_

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Person responsible for payment (**if different than above**): \_\_\_\_\_

Social Security number for person responsible for payment: \_\_\_\_\_

Billing Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Please note any restrictions on contacting you: (e.g., Do not leave messages at work phone)

\_\_\_\_\_

\_\_\_\_\_

