SUMMERVILLE PSYCHIATRIC ASSOCIATES

PRACTICE POLICIES

Office Hours

Our practice hours are from 9:00 am to 5:30 pm Monday-Thursday and 9:00am to 12:00pm on Fridays. Our practice staff are at lunch from 12 pm-1:00 pm each day. If you need to speak to a member of our staff or leave a confidential voicemail for your therapist or doctor, please contact our office at 843-900-6767.

Emergency Situations

Our office does not have on-call hours as we are not an emergency facility. If you believe you or the patient are at immediate risk of harm to themselves or someone else, we will always recommend seeking emergency care through a hospital, emergency room, or 911. This will not affect your ability to be seen in the future through our practice.

Appointments and Cancellations

Please give **24-hour** advance notice for cancellations. **Cancellations for Monday must be made by the previous Friday.** Appointments may be cancelled by contacting our office and speaking with or leaving a message for our practice staff, or through our patient portal. **Please do not leave voicemails for your therapist and/or doctor to cancel your appointments.** Your therapist and/or doctor reserve the right to charge the full session fee for no shows or late cancellations. This is necessary because a time commitment is made to you and is held exclusively for you. Insurance does not cover no shows or late cancellations. Patients are responsible for all no show and late cancellation fees. We make every effort to provide patients with reminders for appointments via email, text, or voicemail, however, **you are responsible for your appointments.** If you are unsure about an appointment date and/or time, please contact our office or check your appointments through our patient portal.

Insurance

As a service to our patients, we submit your claims to your insurance company. Our office and billing company will make every effort to obtain accurate information about your benefit and limits of coverage and will try to have this information available to you. **YOU ARE RESPONSIBLE FOR YOUR BILL**. You agree to pay any charges that your insurance does not pay. We highly encourage you to contact your insurance company to be sure that you understand the limits of your coverage.

Minors

If you are a minor, your parents may be legally entitled to some information regarding your treatment. Your therapist or doctor will discuss with you and your parents what information is appropriate for them to receive and what information is kept confidential.

For Patients under 16 years of age and others who are unable to give voluntary consent, we choose to follow the same guidelines except for revealing information helpful to the patient's progress in counseling. Often, we speak with the patient before speaking with the appropriate guardian regarding confidential information, but there are some exceptions that always occur due to the best interest of the patient.

Confidentiality

Information regarding your treatment will not be released unless there is written consent, an indication that clear and immediate danger exists, a court order which directs the release of information, or you disclose sexual abuse, physical abuse, or neglect a child under the age of 18. We ask that you sign the following consent so that we can provide the information that your insurance company requires to ensure that your treatment is medically necessary and appropriate.

Authorization to Release Information

I authorize my mental health practitioner to release information about me to my insurance company and the Professional who referred me. This information is protected under the Privacy Act, the Drug Abuse Office and Treatment Act, and the comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act.

Consent to Examination and Treatment

I consent to have Summerville Psychiatric Associates and its professional staff perform or order examinations, psychotherapy, and/or related mental health treatments.

I consent to have medications ordered when deemed necessary or advisable by the appropriate members of the professional staff and/or consultants in consultation with Summerville Psychiatric Associates, LLC.

Please note that we do not participate in Disability Claims, Worker's Compensation, or Court Mandated Counseling.

Name (Print):_____

Signature: _____ **Date:** _____