

INFORMATION FOR PATIENTS

Julia J. Tate, JD, LCSW

5606 Cloverland Dr. #107

Brentwood, TN 37027

615-783-2892 phone

615-310-2831 cell

Julia@CloverlandTherapy.com

Office Hours: I keep varied hours but my office is open weekdays from 9:30 a.m. to 6:00 p.m. If I don't answer your telephone call, please leave a message on voice mail. I check my messages several times a day. I will return your call. If you don't hear from me as soon as you need, please feel free to call me again or call my cell phone.

Emergencies: If you have an emergency and can not get in touch with me, call the Crisis Line at 615-244-7444 or go to the nearest emergency room and let them know you're in therapy with me. You may reach me by calling and leaving a message on my voice mail or you may call me on my cell phone.

Fees: You are responsible for the fees for the services I render to you. My fee is \$100 per session (unless we have agreed on another rate). I will bill your insurance for you, however, if your insurance denies coverage, you are responsible for these fees. Additionally, most people are responsible for a copayment and/or for a deductible before their insurance will provide any coverage. This co-pay or deductible is your financial obligation. You are responsible for making this payment on the day of your appointment. If we don't know how much your co-pay is, I ask that you make payments of \$25 per session toward your co-pay until we find out the exact amount. I will refund any overage if your co-pay is less than \$25. For telephone conversations which are longer than ten minutes, I will bill you at the rate of \$100 per hour (unless we have agreed on a different rate). Please be aware that your insurance company will not cover the expenses of phone consultations. If you do not pay the amounts for which you are financially obligated, I will take legal steps to collect these amounts. If I have to take these legal steps, you will be responsible for the expenses of collecting this debt from you, including attorney's fees.

Confidentiality: I will hold what you say to me in the strictest confidence. There are, however, some serious legal limitations on confidentiality if you are or another person is in serious danger. I will explain this to you in more detail in our first session. Additionally, I need your permission to communicate with your insurance company in order to process your insurance claims. By signing this document, you are giving me permission to communicate with your insurance company to the extent necessary to process these claims. Most insurance companies require that I communicate with your primary care physician, to improve the quality of care that you receive from both of us. I will ask you to sign a release to allow this communication. If you have any reservations about providing this release, please let me know.

Cancellations: I require a full 24 hours notice if you have to cancel an appointment so that I can offer that time to another person. Please call as soon as you know that you will not be keeping your appointment. If you do not give me 24 hours or more notice that you are canceling your appointment, I will bill you for that session. Please be aware that insurance will not cover the charges for a cancellation without adequate notice. This will be solely your responsibility. The amount you are charged for cancellation without 24 hours notice will likely be more than the co-pay for which you would have been responsible if you attended your session.

Please feel free to ask any questions you may have about this information sheet or other matters. I am committed to providing you the highest quality service and to being your partner in your recovery.

Date: _____

I have read and agree to everything in this information sheet and I have received a copy of this information sheet to keep.

Patient: _____

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This is a copy for you to keep.