SUSAN CARTABUKE SULLIVAN APRN., BC

Statement of Policies

After discussion with my therapist Susan C. Sullivan I ______________________
____,

Understand the four policies below.

I. Payment and Session Length:

- Payment is expected at the time of each session.
- Payment is requested at the beginning of each session.
- Kindly have your check written prior to sesson, if paying cash prepare exact change.
- An individual psychiatric evaluation lasts 1 hour.
- An individual psychotherapy session last 45 minutes.
- An individual medication management session last 20 minutes.

II. Financial Responsibility for Appointments Cancelled Without 24 Hours Notice:

- I will be financially responsible for all appointments cancelled without 24 hours notice.
- I understand that, with the sole exception of cancellation forced by severely inclement weather or acute illness, this policy is enforced for all situations, and that the charges for a missed session are not reimbursable under third party insurance programs.

III. Confidentiality:

- All information shared in psychotherapy sessions is confidential, with these four exceptions:

1. I am in danger to myself or others, my therapist is mandated by law to report it.

2. If there is suspected current physical or sexual abuse of a child, my therapist is mandated to report it.

3. If my therapist and /or my records are subpoenaed by court of law, my therapist must comply.

4. If an attorney must be employed to pursue any unpaid fees, he/she would learn that I had been seen here, but would not learn what was discussed.

IV. Accessibility to Therapist:

- I understand that Susan Cartabuke Sullivan APRN., BC has a 24 hours answering machine and that all efforts possible will be made to return call as soon as possible. I understand that if there is a medical emergency I can contact my therapist by pager at 631-370-3760. If I do not receive a call back then I should contact the nearest emergency room for emergency treatment. I also understand that there may be times when my therapist is not available and that every effort will be made to have coverage if necessary.

- I understand that I will be referred elsewhere if I require guaranteed, 24 hour access to a therapist. I recognize that there might be time when this is not available.

I acknowledge that I have read and discussed the above stated policies with my therapist and will comply with the terms of this agreement. I also acknowledge that I have received a copy of this policy.

______________________________ ______________________________

Susan Cartabuke Sullivan Date Signature Patient Date