Rosemarie Calleros PhD, MFCT
Clinical Psychologist, #Psy 12881
Marriage, Family and Child Therapist, #Mv 18234
4 Montpellier, Laguna Niguel, CA, 92677
(P) 949-916-8271 (F) 949-499-2397 Email: rmcallerosphd@cox.net

OFFICE POLICY

FEE SCHEDULE: $150 per 45 minute sessions for Individual, Couple, or Family Sessions;
$175 for 60 minute sessions.
$200 for Initial Sessions.
$225 per hour for Psychological Testing (includes- testing time, scoring interpretation and report writing.)
$4 per minute for URGENT calls.

PAYMENT FOR SERVICES: Payment is due at the time services are rendered and must be paid by cash or check. Kindly have your check written prior to the session.
I understand that I am financially responsible to pay all fees denied by my insurance.

Patient Initials_____

KEEPING APPOINTMENTS: Therapy sessions are 45 or 60 minutes. The last few minutes are generally reserved to review the session and schedule any further appointments. Time is reserved only for you. A missed appointment or sessions cancelled less than24 hours are charged $75 and cannot be billed to the insurance. After two "NO-SHOWS"our doctor-patient relationship will formally be terminated.

Patient Initials_____

EMERGENCIES: If you are in imminent danger call 911, your nearest police station, or emergency room. Otherwise leave a message on my voice mail. Also, my voice mail will have an alternate number where I can be reached in an emergency.

CONFIDENTIALITY: All information between therapist/doctor and patient is held strictly confidential unless;

1) You authorize release of information with your signature. 2) Your present a physical danger to self or others; or 3) child or elder abuse is suspected.

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

CONSENT FOR TREATMENT: I further authorize and request that my Psychologist carry out psychological examinations, treatment, and/or diagnostic procedures which now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, it at times may be difficult and uncomfortable.

Patient Initials_____

Release of Information to Health Plan: I authorize the release of information for the benefit of my Health Plan. Patient Initials_____

Release of Information to Primary Care Physician and/or Psychiatrist:
I authorize the release of information to my primary care physician.
Primary Care Physician (name)_____
Psychiatrist (name)_____ for purposes related to my health.
Patient Initials_____

I Provide Therapy: I do not get involved in work grievances, lawsuits, custody disputes, disability determinations, work excuses and requests for change in job conditions or other legal or administrative proceedings.
I have read the attached Health Insurance Portability and Accountability (HIPAA) form.
I understand and agree to all the above information.

Patient name_____ **Signature**_____ **Date**_____