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PATIENT AGREEMENT AND NOTIFICATION

This document contains important information about my professional and business practices. It explains many of your rights and responsibilities and will represent an agreement between us, unless it is amended or terminated in writing.

PROFESSIONAL SERVICES: Treatment may include discussion of issues that are uncomfortable for you. While I am using my best professional judgment for your well-being, I can't guarantee that you will obtain the results you seek. You have the right to challenge any aspect of the treatment I recommend. If you believe that I have mismanaged your treatment or your privacy please discuss this with me and you may also report any concerns you have to the Board of Behavioral Sciences at (916) 574-7830.

CONFIDENTIALITY: In general, the confidentiality of all communication between a patient and a mental health professional is protected by law and can only be released with your written permission. However, there are some situations when I am entitled, or required to release patients' protected health information without their authorization. To improve your treatment, I can release this information so that I can consult with other professionals. In some situations, I can also be compelled to release patient records by the courts and by the Board of Behavioral Sciences.

In the following situations, I must take action to protect people from harm, even though that requires revealing some information about a patient's treatment. If I believe that a child, an elderly person or a patient is threatening serious harm to themselves or others, I am required to take protective actions which may include contacting authorities, family members or others who can help provide protection.

The standard of my profession require that I record and maintain appropriate treatment records.

CONTACTING ME: Due to my work schedule, I am not immediately available by phone. While I am usually in my office between 11:00 a.m. - 8:30 p.m., I will most likely not answer my phone. I will make every effort to return your call the same day with the exception of weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your physician or nearest emergency room and ask for the mental health professional on call. If you feel that you need immediate assistance or there is a life threatening emergency, please call 911 or the local police. If I am away on vacation, please feel free to reach out to my colleague while I'm away.

FEE POLICIES AND PROCEDURES

- 1.** I accept various forms of payment including credit card payments which can be processed from my website.
- 2.** I don't accept insurance but I will be happy to provide you with a super bill that can be submitted for possible reimbursement. I will help you with the forms. I only require being paid up front. Any insurance reimbursement will go directly to the patient.
- 3.** I will ask you for authorization for credit card payment of any fees not paid in full at the end of the calendar month or within one month of receipt of the statement. In the event there is any problem with collecting fees, I will charge interest of 1% per month on the outstanding balance. In the event I/we must incur costs to collect fees, those costs will be the responsibility of the client.

4. Cancellation Policy: If you need to cancel or reschedule an appointment, please call us as soon as possible and not less than 48 business-day hours in advance to avoid a charge (i.e. canceling a Monday appointment on Friday is not sufficient notice). If you do not cancel at 48 business day hours in advance, you will be responsible for the fee for the session. I have this policy in place because a time commitment is made to you and is held exclusively for you.

5. By engaging in treatment, you are agreeing to pay the fee for each 45-minute (or 60-minute) session at the time of service. Additionally, if it is necessary for me to make phone calls, review documents or write documents as part of my services to you, those services will be charged to you at the same rate as for direct treatment.

+++ A version of this form will be provided during your first visit session with fee information and space requiring signatures for all parties involved — Casey Weitzman, MA, LMFT (treatment provider), you (the client), and/or the client’s legal guardian (if applicable). Signing this form will indicate that, collectively, we have read and understood the contents of this form, and are willing to abide by the above agreement.