Susan Buckler-Miller, MSW, LSW
11 Majestic Drive
Danville, PA 17821

Welcome to the practice of Susan Buckler-Miller. I appreciate that you have chosen me to be your mental health provider. Please read and sign this office policy statement in order to indicate your understanding of office procedures and consent to receive treatment services within these guidelines.

Confidentiality of Records:

All written and spoken information related to counseling services is confidential. Written authorization is required to release any of your records to a third party. If you want to have any information released to a third party (attorney, insurance company, etc), you or they should request release of information in writing, authorized by your signature. The legal exceptions to confidentiality involve information regarding suspected child abuse, potential harm to self or others, and when a court may subpoena records. Notice of how medical information about you may be used and disclosed and how you can get access to this information is located in "Notice of Privacy Practices".

Appointments:

All services are provided by appointment. Length of sessions can vary depending on treatment needs. Intake sessions can vary in length and the number of sessions can vary depending on your insurance coverage. Appointments are typically 45 to 50 minutes. To schedule your appointments, call me at (570) 275-1191 or (570) 490-1679.

Cancellations and Missed Appointments:

If you are unable to keep your scheduled appointment, please notify me at least 24 hours in advance. Without prior cancellations, you will be billed $50.

Fees:

My fee is determined by time and client service. Therefore, I can review with you your responsibility for services rendered. In the event that you experience significant financial difficulties with payment of your bill, please discuss your circumstances with me.

Payment in Full or Co-Payment is Expected at Time of Service:

If I except your insurance, your managed health care plan or health insurance will be billed and I will follow contractual obligations by the insurance companies. Clients have the obligations to be aware of the provisions of their health insurance and their requirements to obtain benefits. Clients are responsible for non-covered services.

Agreement to Contact Primary Care Physician:

Release of Information for contacting your primary care physician.

I **decline** to have my primary care physician contacted

I **agree** to have my primary care physician contacted

Name of Physician_____ **Telephone**_____

Please feel free to ask any questions you may have regarding the above policies before signing below. Your signature indicates that you have read the Office Policy Statement and agree to the above stated conditions.

I have read and understand this policy agree to abide by it accordingly.

Signature (client, parent, legal guardian) Date