

DEBBIE GLOVER, LPC

POLICIES AND PROCEDURES/CONSENT FORM

OFFICE HOURS: Clients are seen by scheduled appointments. For after-hours calls, please contact 843-860-8518 and leave a voicemail message and someone will return your call as soon as possible, usually the following business day unless there are extenuating circumstances. If you have a life-threatening emergency, please call 911 or go to your nearest emergency room. You may also contact one of these resources in an emergency: your physician, Charleston County Community Mental Health Centers Crisis Team (843-414-2350), Dorchester County Adult Counseling Services (843-871-4793), or Berkeley County Children and Family Services office (843-577-0772), or your closest emergency room.

CANCELLATIONS: Please give 24-hours' notice of canceled appointments if possible. I do understand life "happens" and sometimes you are unable to give 24-hour notice. Continuous 'no show' appointments may be billable at \$25.00 if necessary and may result in termination of services. *****IF YOU ARE SICK, HOWEVER, PLEASE LET US KNOW AND WE WILL BE HAPPY TO RESCHEDULE. ESPECIALLY DURING FLU SEASON, WE WANT TO MAKE SURE EVERYONE REMAINS AS SAFE AS POSSIBLE**

FEES: My fee schedule is \$125.00 per counseling hour. I will be happy to bill your insurance company, and if you have a billable copay, I can take credit/debit cards, cash or personal check at time of service. If you need arrangements, please let me know and I will help you as I can. If you need a sliding scale fee, please let me know and I will try to work with you as well. I will also be happy to refer you to community resources if financially therapy will be a hardship—there are county mental health agencies and additional resources available in our community. ****Please note incidental paperwork including filing for short term disability and FMLA are services that are not covered by insurance but are billable at \$125 per hour.**

CONFIDENTIALITY: Information regarding your treatment will be kept in strict confidence and will not be released unless there is a written consent, or under conditions required by law: threat of harm to self or others; an order of the court; disclosure of sexual or physical abuse or neglect of a child under the age of 18, a vulnerable adult (for example mentally challenged or physically handicapped), or an elderly adult.

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION

I authorize Debbie Glover to release information about me to my insurance company, the professional who referred me, and any individual to whom I request it be released. I am aware that at times this office uses outside agencies including fax services and additional office personnel who will be aware of certain aspects of my treatment which may include protected health information in order that services be rendered and reimbursement made to my provider, Debbie Glover, LPC.

CONSENT TO EXAMINATION AND TREATMENT

I hereby give my consent to Debbie Glover, LPC to provide psychotherapy services.

I have read and understand all the information stated above and I am in agreement with these policies and procedures as presented.

Signature:_____ Date: _____