Welcome to my practice. Your agreement to the following terms and conditions is required for you to receive professional services from me. If you do not agree, I will be glad to give you referrals to other providers.

CLINICAL SERVICES:

You consent for yourself to receive a comprehensive diagnostic assessment. At the end of the evaluation, we will mutually decide if we will continue treatment together.

For emergencies outside of our appointment, If there is potential for any physical danger to you or others, you will call 911 immediately or go to the closest emergency room. To reach me outside of standard business hours, follow the instructions on my voicemail.

Note I do not have admitting privileges, nor am I affiliated with or on staff at any hospital. Should I deem more intensive services are needed than I can provide, I will do my best to ensure safety and obtain the appropriate level of care, but I cannot provide that care directly and cannot guarantee the receipt or quality of care that others provide.

All communication and clinical treatment will be documented in your patient chart. Both the law and the standards of the profession require such. I will be happy to provide the records to an appropriate mental health professional of your choice or to prepare an appropriate summary instead once a release of information is signed.

- If you are seeing me for medication management only: You agree to see me in person or by tele-health no less than every six months for follow-ups
- If you are seeing me for psychotherapy: Psychotherapy has both benefits and risks. Possible risks include the experience of uncomfortable feelings (such as sadness, guilt, anxiety, anger, frustration, loneliness, or helplessness) or the recall of unpleasant events. Potential benefits include a reduction in feelings of distress, better relationships, better problem-solving and coping skills, and resolution of specific problems. Given the nature of psychotherapy, it remains an inexact science and no guarantees can be made regarding the outcome.
- For Telehealth appointments: you agree that you are in the State of Pennsylvania only during the entirety of your appointment. You agree not to be in a moving vehicle during your appointment. You agree to find for yourself a private space where confidentiality can be maintained during your appointment.

CONFIDENTIALITY:

There is no guarantee of confidentiality under the following conditions:
● If I suspect you are in imminent danger of harm to self or others, or a child or elderly

person is being abused or neglected (as I am a mandated reporter)
● If a court orders a release of information
● If you initiate a malpractice lawsuit, or a billing dispute with a financial institution
● If you pay by credit card, my name will appear on your credit card statement
● If you do not pay your bill, your balance due statement (including diagnostic and procedural codes) may be sent to a collections agency or other responsible party
● Between me and my administrative staff

HIPPA:

You confirm you have reviewed my HIPAA privacy practices here: www.ruthsteinmanmd.com

PAYMENT:

You agree to pay professional fees as follows:

Initial Evaluation : $550

Psychiatric Treatment 50 minutes: $

275.00

Psychiatric Treatment 25-30 minutes:

$220.00

FINANCIAL AGREEMENT

Professional Fees:
• Payment in full is due at time of service. Payments may be made with cash, check, credit card (Visa/MC/Discover/American Express)
• Special financial arrangements must be discussed prior to your appointment
• Parents/Guardians are financially responsible for payment for services provided to legal dependents.
• $25 processing fee will apply for any returned check
• Fees may include charges for other professional services such as:
1. Report writing
2. Extended telephone conversations
3. Preparation of records or treatment summaries
4. Legal proceedings, including preparation time and transportation

Payment of Services:
• I understand that I, not my insurance company, am responsible for full payment of my

fees.
• I understand that I am responsible for payment of any balances on my account. If my account is referred to a collection specialist, I will be responsible for actual collection costs incurred, including all attorney's fees and court costs. Dr. Steinman may deny subsequent patient treatment if my account balance remains unpaid.

Policy for Missed Appointments and Cancellations:
• I understand that appointment times are reserved exclusively for me.
If I do not cancel my appointment within 24 hours of the appointment time, I will be charged the full amount of the scheduled time. To avoid missed appointment or late cancel fees, I agree to call 24 hours in advance to make any changes to my appointment.
• For Monday appointments, I will call the previous Friday by noon.
• I understand that this practice requires a credit card number stored via encryption in your chart to be used in the event of a late cancellation or no-show appointment

- By your electronic signature of this form, you authorize charges to your credit card through Stripe via SimplePractice for services rendered. These charges will appear on your bank/credit card statement as Ruth Steinman, MD. You have the right to request a paper copy of this document.
- I authorize Ruth Steinman, MD to charge my credit card through Stripe.
- I agree that my credit card can be charged for any session that is not cancelled at least 1 business day prior to the scheduled session. Cancellations for Monday appointments need to be made by 12 pm of the Friday preceding the appointment.
- I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Ruth Steinman, MD in writing of any changes in my account information or termination of this authorization.
- I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form. I acknowledge that credit card transactions could be linked to Protected Health Information.

Information about Shared Office Space:
Dr. Ruth Steinman shares office space with other health professionals. Although she and the other clinicians share certain office expenses, Dr. Ruth Steinman is completely independent in providing clinical services, and she alone is responsible for those services. Dr. Ruth Steinman's professional records are separately maintained and secured. She alone has access to those records.

BY SIGNING THIS AGREEMENT, I HAVE READ ALL ITEMS AND ACCEPT ALL TERMS