



106 Caty Lane  
Charlottesville, VA 22901  
voice 434.978.3900 fax 434.978.3933  
[www.acamentalhealth.com](http://www.acamentalhealth.com)

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## Practice Policies and Procedures

Welcome to Albemarle Counseling Associates, PLLC. This document contains information about the professional services and policies which are an integral part of our work together. Please read this document carefully, and feel free to ask any questions you may have.

**Appointments:** Initial appointments are 60 minutes in length, to allow time for us to review your history, and to determine some of your challenges and goals. Follow-up counseling sessions are typically 50 minutes in duration, which begins at the scheduled appointment time. **ART sessions require 60 minutes or more and cannot be provided upon late arrival.** Except in rare situations and emergencies, you will be seen at your scheduled time. This time is set aside for you, so it is important that you keep this appointment. **Twenty- four hour notice is required for cancellations. There is a \$150.00 fee for missed appointments with less than 24 hour notice.**

**Insurance:** I am in network with some insurance providers. If you pay through your insurance or wish to submit statements for out-of-network reimbursement (provided at your request), your private health information (PHI) is shared with your insurance company. If you wish to keep your PHI from your insurance provider, you can choose to pay privately. Information regarding out-of-network benefits are provided by your insurance carrier. I can provide assistance with this as well.

**Communication:** You may leave a confidential phone message at any time. I will do my best to return your call within 24 hours. Please leave a convenient time to return your call. Email contact is also available, however email is not a secure medium to share detailed, protected health information. For this reason and for your protection, I will not discuss clinical information via email or text.

**Confidentiality:** Your privacy is extremely important to me and is protected by laws and ethics. Your permission is needed prior to any release of information, except in special circumstances. *Please refer to the HIPAA notice provided to you for further information.* Please note the limits of confidentiality that apply to all mental health professionals and mandated reporters.



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**Authorizations:** Information shared between Albemarle Counseling Associates, PLLC and any of your providers, family members or supports, requires your authorization. If you wish to include others, or if we agree this would be beneficial to your treatment, you will be asked to sign a release form.

**Emergencies:** Every effort will be made to assist you, especially in times of crisis. There may be times when contacting you will not be possible. Therefore, you must agree to first call 911 or go to your nearest Emergency Room for assistance, any time you suspect you are in crisis.

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## Consent to Treatment

I acknowledge that I have read (or have had read to me), and understand the information in the Practice Policies and Procedures for Albemarle Counseling Associates, PLLC described above, and that my questions have been answered fully.

I hereby seek and consent to take part in psychotherapy with Albemarle Counseling Associates, PLLC. I understand that no promises have been made to me as to the results of treatment or any procedures provided.

I agree to enter into a professional business arrangement according to all business practices outlined in this agreement. I accept financial responsibility for payment of all fees and services as described, regardless of insurance coverage or any other third-party payers.

I am aware that I am required to provide at least 24 hour notice to cancel an appointment. **I understand that there is a \$150 cancellation fee for appointments missed with less than 24 hour notice.**

I am aware that I may stop my treatment at any time, however I will be responsible for service fees for treatment that I have already received.

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Signature (client or parent/guardian) Date

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Date

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Print Name

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Relationship (if applicable)

Updated 03.20.2020