Katie Zezima McCabe, LCSW

Office Policies

Appointments and Cancellations
I will work with you directly to schedule our sessions. Full session fee may be charged for cancelled or missed appointments unless at least 24 hours notice has been given.

Payments and Fees
All fees are due and payable upon completion of your visit, unless prior financial arrangements have been made. Any collection, legal fees, or costs necessary to collect unpaid balances will be the client's responsibility. The fee for a returned check is $50.
Please note that I will be unable to schedule future appointments if an account balance exceeds $1,000.
A credit card number is requested at the initiation of treatment in order to ensure prompt payment. If you choose to make your payment with a credit card, your card will be charged weekly for sessions.

Schedule of fees:
Initial intake evaluation, 60-75 mins: $275
Individual psychotherapy, 45-50 mins: $225
Family therapy, 50-60 mins: $250
Home visits and off-site meetings: pro-rated based on session and travel time based on a rate of $250/hour
Group therapy, skills training, or family skills training: priced accordingly

Medical Insurance
I do not deal directly with insurance carriers. A statement for any out of network insurance reimbursement will be provided to you at the end of each month. The statement will include a diagnosis code and a description of services rendered. It is recommended that you submit claim forms as soon as possible to your carrier and keep a copy for your records.

Telephone, E-mail, and Text Access
In the event of an emergency, please leave a message at 203.326.6730. I will respond to your message within 24 hours. If a situation requires an immediate response, please call 911 or go to the nearest hospital emergency room.

Email should be used primarily for communicating logistical information. Clinical information and advice cannot be sent via email. Text will be used similarly, unless agreed upon to be used for skills coaching.

Notice of Privacy Practices

Information about my patients remains confidential whenever possible. This is essential to develop the trust and openness needed for mental health treatment. When I believe that release of information would be beneficial to treatment, I will request written consent by an Authorization for Release of Information. It is your choice whether to permit such contact or not, and you may revoke (in writing) any permission given at any time.

3 Sylvan Road South Westport CT 06880 203.326.6730 katiemccabetherapy@gmail.com

Under federal law you have certain rights regarding the personal health information I collect and maintain about you:

1. Request that I restrict certain uses and disclosures of your personal health information; however, I am not required to agree to a requested restriction.
2. Request that I communicate with you by alternate means, such as making records available to be picked up or mailed to an alternate address.
3. Request that we amend your personal health information record if you feel that the record is incorrect.
4. Request a description of requests for your personal health information, including date of request and requested name and mailing address.
5. Request an additional copy of this information.

If I am not able to satisfy your request, I will contact you in writing stating the reason for denial of any request.

There are rare circumstances in which the law may require a health professional to release information about you without your authorization, such as:

1. If I have reason to believe that you pose a direct threat of imminent harm to any individual (including yourself).
2. If I have reason to believe that abuse or neglect of a child, elder, dependent, or disabled person is taking place.
3. Although patient / therapist communications are generally protected as confidential under the law, I may be required to use or disclose information about you in the course of a judicial or legal proceeding if I am ordered by a court to do so. I also reserve the right to use and disclose information about you if doing so is necessary to defend myself in legal action brought against me in relation to your care.

When information needs to be released, I will strive to protect your privacy and share only that information which it is legally necessary to disclose.

I have received and reviewed a copy of the Office Policies and Notice of Privacy Practices:

Signature: ____

Printed Name: ____

Relationship to Patient: ___________________________ (self, parent, legal guardian)

Date: ______________________ DOB: _________________________________

Credit Card Information

Name on card: ____

Type: Visa / MasterCard / American Express

Card Number: ____

Security Code: _______________________________ Expiration: ________________________________

Billing Address: ____

____

Email (for receipts): ____

Signature: ____

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