Timothy R. Gerbracht Psy.D. LLC
WASHINGTON SQUARE
109 Park Washington Court, Falls Church, VA 22046
(703) 533-5825 x 304   Fax (703) 533-8431

I hope this description of my professional services and billing procedures will answer any questions you may have. Please feel free to ask any unanswered questions and to discuss other concerns you have as the need arises.

1. Professional Services Offered:

I am engaged in the practice of individual, group, and family psychotherapy with children, adolescents, and adults. I also provide training, consultation and supervision to individuals, groups and organizations.

2. Length of Treatment:

Goals of treatment are arrived at by mutual collaboration through exploring the issues and concerns you feel to be most pressing and important. The length of treatment depends upon the goals we establish together. Treatment typically involves meeting one or two times per week. In some instances, other treatment schedules maybe useful including daily or monthly sessions. The schedule of sessions will be agreed upon during the first few meetings, and may be modified during the course of treatment. It will be very important for you to keep your scheduled appointments in order to receive maximum benefit from treatment.

3. Appointments and Fees:

Each session is generally 45 minutes in length. Group sessions are generally 55 minutes. Longer sessions are sometimes advisable for more intensive individual and parent/family work. Fees for services are described below. Fees generally reflect the usual and customary charges in our area. Please feel free to discuss the fee structure as well as any concerns you might have.

Fees for professional services may be reimbursable by most insurance carriers. It is usually best to contact your insurance company to inquire about the extent and provisions of your policy, so that your expectations of coverage are realistic. All insurance companies vary in their coverage for mental health and frequently change their policies annually. Although I prefer not to accept direct insurance reimbursement (unless previous arrangements have been made), I will complete any forms or documents necessary for you to obtain your reimbursements. My billing statement has all the information required by most insurance carriers. For reimbursement, please attach my statement to your claim form and submit it directly to your insurance company.

Full payment is due at the time services are rendered. A 5% monthly interest rate charge may be incurred for all accounts with outstanding balances for more than thirty (30) days. Payment becomes past due thirty (30) days after a statement has been issued. If collection becomes necessary, all reasonable expenses, including collection agency and attorneys' fees will be charged to the client. If the use of a collection agency or attorney becomes necessary, it is important to be aware that your right to confidentiality is curtailed. While no clinical information would be revealed, your name and amount owed becomes available to these agents.

If there is an adverse change in your financial status, we may adjust the fee structure together to reflect this change accordingly. If there is an increase in fees, you will receive advance notice and may discuss these changes directly with me should you have questions or concerns.

Please note, there will be a $20.00 charge for returned checks.

Fees for Services:

Individual psychotherapy: 45 minutes ………… $250.00

Family psychotherapy: 45 minutes ………… $250.00

Group psychotherapy: 55 minutes ……….……………….... $110.00

Case management, extended telephone consultations, extended insurance management, school visits and preparation of letters per 45 minutes …………………………………………….. $250.00

Emergency psychotherapy services (sessions, phone calls, case coordination, etc. per 45 minutes …………………………….. $250.00

4. Cancellation Policy

Your appointment time is reserved solely for you. Sessions missed for pre-arranged vacations or for illness will not be charged. Because your appointment time is reserved solely for you all other missed sessions will be billed. Please be aware that most insurance companies will not compensate for missed appointment times and the cost will be your sole responsibility.

5. Telephone Accessibility:

You can leave a confidential message for me at the following number: (703) 533-5825 x 304.
If your emergency is life threatening, proceed independently to the nearest hospital or call 911.

6. Medication:

If medication is indicated as part of your treatment, I will discuss various referral options with you. If it seems advisable to obtain a psychiatric consultation to assess the need for medication, I will refer you to one of the psychiatric consultants that I work with or talk with your family physician.

7. Confidentiality:

Confidentiality is your expectation about privacy concerning information you disclose during your

consultations with me. I am bound to hold in confidence nearly all that is disclosed, including the fact that you consulted with me. In group or family sessions, where private information may be shared with other individuals in addition to myself, the limits and expectations about

confidentiality will be made clear in advance, so that each participant understands who will know what. There are, however, situations where the rule is excepted. They are as follows:

(A) If it suspected that child abuse has occurred, the Commonwealth of Virginia requires that it be reported to the Department of Social Services. Child abuse includes neglect of medical needs, abandonment, sexual exploitation and physical or mental injuries that result in impaired functioning.

(B) If you are a Virginia licensed health care provider and that, due to substance abuse or emotional stress, you are unable to practice competently or pose a danger to your patients, the law requires that it be reported to the appropriate authorities.

(C) If you are in clear or imminent danger to yourself or another person, I must notify the appropriate authorities to prevent that occurrence.

(D) In a legal proceeding, patient-therapist communications are privileged with the following limitations: (1) only for civil actions; (2) only for individual therapy, not couples or family sessions; (3) not if your mental status is an issue before the court; (4) unless the judge believes that these communications are necessary to the proper administration of justice.

In addition to the above legal limitations on confidentiality, I ask that your grant me the permission to share information when necessary with my colleagues at Washington Square. If I am out of town, one of my colleagues will be available to provide emergency coverage and may need access to relevant information to provide interim care, should the need arise.

Finally, if you are seeking third party reimbursement for psychological services, the third party payer has the right to request information for determination of your eligibility for payment. Your signature on the claim gives consent for me to disclose dates of treatment, type of treatment, and the nature of your problem or illness (diagnosis). If I am billing the third party payer, I will need your signature on file consenting to disclosure of the above information.

*** Please keep this policy statement for your records and return the following signature page with any other intake documents ***

Signature Page, Policy Statement for Timothy R Gerbracht, Psy.D., LLC

I HAVE READ THE ABOVE POLICIES, UNDERSTAND, AND AGREE TO THEM.

______________________________ ______________________

Your signature Today's date