

## Michael Kaplan, LCSW, LLC

### Policies

#### 1. No-Show and Cancellation Policy

Please call with as much warning as possible if you need to cancel or reschedule your appointment. If you do not call at least 24 hours prior to the session, you will be charged for the session. If you do not show for your session and have not called prior to that session, it is considered a “no-show.” Three “no-shows” will result in termination of therapy.

#### 2. Late Policy

In order for me to keep my appointments on schedule, I will start and end sessions on time. If you are late, your session will still end at the scheduled time and you will be billed for the entire session.

#### 3. Payment

I am an in-network provider for Anthem/Blue Cross/Blue Shield, HealthLink, and MHNet insurance. For other insurance plans, I am considered an out-of-network provider. At your request, I am happy to provide an invoice that you may submit to your insurance company to request reimbursement for my services as an out-of-network provider. A sliding-scale rate is available to a limited number of clients who cannot afford the regular fees. Please ask for more information if you are interested in the sliding-scale rate.

Regular fees are as follows:

- \$65.00 per full session (approx. 60 minutes)
- \$35.00 per half session (approx. 30 minutes)

Consultation (one-time meeting or phone call, 20-30 minutes, to gather information and offer impressions/recommendations): No charge.

Payment is due at the time of service. I accept checks and cash.

#### 4. Phone Calls

If you need to speak with me for any reason before your next scheduled appointment, please call (573) 529-9065. If I am not available, please leave a message on my voice mail. I will check my voice mail twice a day during regular business hours and I will return your call as soon as possible. If you have an emergency and you are unable to contact me, **you should call 911 or go directly to the emergency room of your local hospital.**

#### 5. Confidentiality

Everything we discuss will be kept confidential. I will not release any information about you to anyone without your written consent to do so. The limits to this confidentiality include: 1) if I believe you are a danger to yourself or others, and 2) if I become aware of any minor that has been abused or neglected. Please see the handout “What You Should Know about Confidentiality in Therapy” for more information.

#### 6. Consultation

In order that I may always provide the best care possible, I do consult with colleagues, namely Christy Hutton, PhD; Diana Walz, LCSW; and Pat Beglau, MA, LPC, regarding the contents of therapy sessions. Only your first name will be used and all other identifying information will be omitted.

#### 7. Consent

By signing this form, I acknowledge that I have read and understand the information contained herein, including consent for Michael Kaplan, LCSW, to release information regarding the contents of my therapy sessions to the above-named individuals for the purpose of consultation.

\_\_\_\_\_  
Client's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Michael Kaplan, LCSW

\_\_\_\_\_  
Date