Douglas L. Bennett, Ph.D., MBA
Clinical Psychologist
3 W. Main Street, Suite 202, Westerville, OH 43081
doug.bennett@bennettevolution.com phone: 614-682-2124

GENERAL OFFICE INFORMATION

Appointments:
Each individual, conjoint, or family session will be allocated approximately 50 minutes unless special arrangements are made. Most new clients are scheduled on a week or bi-weekly basis. Frequency of appointments may vary and should be discussed with me in the first few appointments. If you are requesting a specific appointment time, you may wish to schedule several sessions in advance to ensure you have that time. It is very important that you keep your commitment to therapy appointments. If you must cancel, you will need to provide at least 24 hours notice. Otherwise, you will be billed. The first missed appointment will result in a $50.00 charge. Subsequent missed appointments will be the full session fee as insurance does not cover any part of missed appointments. In cases of a true emergency exceptions can be made.

Parents or guardians must sign paperwork when bringing a minor for psychological sessions. The person who brings the child is responsible for payment according to insurance terms, regardless of custody or payment arrangements. If a teen attends alone, please send payment with them.

This office serves people for various reasons. Please respect others' confidentiality as you would expect in return. Smoking is not allowed. You may bring non-alcoholic drinks. Keep your voice low, especially in the hallways, to avoid disturbing sessions. Children must not be left unattended unless they can sit quietly.

Telecommunication:
You can contact me at 614-682-2124. Since I am often in session, you will likely reach my voicemail. Please leave your name, phone number, and a convenient time for me to call you back. I'll get back to you as soon as possible.

If an emergency occurs during office hours, contact me to inform of the situation; I will reply as soon as possible. For urgent needs before my response or after hours, call your local hospital emergency room or community mental health center's emergency service. In Franklin County, dial 276-CARE or Ohio State Hospital at 614-293-9600—use these only for acute emergencies. Please note, these services cannot connect you directly with me. We should discuss ongoing urgent situations together in our meetings to create a crisis plan.

Fees:The fee for individual, couple or family therapy is $200. For any reports or letters you request from our work, the time for report preparation will be billed at $200 per hour, and that fee will not be covered by an insurance company.

Payment Options: Many clients use mental health benefits from their medical insurance to cover part of the session fee. However, more clients are opting to pay privately for mental health services. Please review the following payment options…

Option #1: Insurance

Please contact your insurance provider prior to your initial session to confirm benefits, including deductibles, copays, and any limitations. Insurance companies often maintain provider panels and may require pre-certification for services. It is your responsibility to verify coverage in advance to ensure eligible services. Co-payments or amounts not covered by insurance should be paid at the start of each session. Checks should be made payable to "Douglas Bennett, PhD." Billing will occur at the time of service. **Regardless of any claims submitted to insurance, you remain ultimately responsible for all fees incurred.** If outstanding bills are unpaid, a collection agency may be engaged, and you will be accountable for any associated legal costs involved in recovering the balance.

Most insurance companies require a mental health diagnosis to approve coverage, which becomes part of your permanent record. They may review or approve your treatment plan against their guidelines, and your clinical information could be accessed by multiple people.

Option #2: Self-Pay

Choosing this option gives you full privacy and control over your treatment. Payment is required at each session by check or cash; no billing will be done. Your clinical information remains confidential. We'll decide together how often and how long your visits will be, based on your needs and budget.

Account Delinquency and Credit Reporting:

I make every reasonable effort to collect payment from insurance companies and patients. Once these efforts are exhausted, I may report unsatisfied accounts to a collection agency of my choice for payment and credit reporting. Before an account is sent to collections, any applied but unearned discounts may be reversed. Additional expenses, usually 35% of the amount sent to collections, are incurred and subsequently added to the patient's balance. If you have an account referred to my external collection agency, your credit may be negatively affected. By signing below, you understand additional expenses, usually 35% above the original debt, will be incurred if your account is sent to collections.

Confidentiality

Ohio law defines our confidential communications as privileged. Please be aware there are certain exceptions or limitations to confidentiality as identified by law. One of these is the concept of imminent danger. In other words, when a person is determined to be a present danger to self or others. Another is the duty to warn protected third parties from risk posed by clients. There is a mandate to report suspected child about to the authorities. Be aware that there is a waiver of privilege in malpractice actions. Whenever you sign a release of information, you authorize the breaking of confidential to the identified party. If you are involved in legal actions where you sign a release of information, I can be ordered to provide information to the court. I will elaborate further in these exceptions if you have questions.

SIGNATURE PAGE

I have read and understood the policy statement and have had questions answered to my satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Please sign here to indicate that you understand and agree to these terms of my care.

_____ _____

Signature Date

I acknowledge that I have received a copy of the HIPAA notice form. I have read this agreement and agree to its terms.

_____ _____

Signature Date