Office, Attendance, and Payment Policy

1. I understand that I will be charged a NO-SHOW or LATE CANCELLATION fee of the cost of the session if I fail to show for my appointment or cancel the appointment on the same day of the scheduled appointment. In the event of a missed appointment, I agree to allow Dr. Wise to contact me by phone or to contact any emergency contacts discussed with Dr. Wise.

2. I understand that I am responsible making payments at the time of my appointments. I understand that cost for initial assessment is $150; subsequent psychotherapy follow-up appointments are $125 per session of any length of time; and psychological testing costs $110 per hour. Psychological testing is billed in one hour increments.

3. I understand that I will be charged a $10 service charge if I fail to make my payment at the time of my appointment.

4. I understand that payment is to be made by credit card at the time of the appointment; Dr. Wise will accept credit card payment by entering my credit card number into a secured/encrypted system; in the future, payment option will be available in the client portal of the electronic health record system.

5. I understand that services are paid out-of-pocket and that Dr. Wise does not participate with any insurance plans.

6. I understand that the initial session will last about 55 minutes and that all subsequent psychotherapy sessions will last approximately 45 minutes. I understand that if I am late to appointments, I will still have to end the session at the allotted time.

7. I am not a member of a military branch/service, nor am I a military family member/dependent. I understand that Dr. Wise is unable to provide psychological services to me if I am a member of the military or military dependent due to Dr. Wise's full-time contractual commitment outside of this practice. In the event that I am misleading about my military or military dependent status, services will be immediately terminated; payments for services will be due; and no superbills can be provided to obtain reimbursement. I am responsible to notify Dr. Wise of any potential change in military/dependent status. Dr. Wise can provide referrals as needed by request.

8. Psychotherapy termination: I understand that psychotherapy is completely voluntary and may be terminated by me as the client at any time. I may resume services by request. In the event that I 1) no-show for an appointment or 2) cancel and do not re-schedule, Dr. Wise will reach out to me twice prior to terminating services. In the event that Dr. Wise terminates services, I may resume services upon request to Dr. Wise. I may also ask for a referral to another provider if needed.

9. Additional fees: I understand that I will pay additional fees at a reasonable cost in the event that I request documents, records, mailings, etc.

10. By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from Dr. Wise.

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Signature of Responsible Party

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Date