

POLICIES REGARDING PROFESSIONAL SERVICES
Pamela A. McCaskill, Ph.D.
Licensed Psychologist #6301012563

CONFIDENTIALITY

Any information that you provide, as well as counseling records that I maintain, are kept strictly confidential, with the exception of life threatening situations, cases of suspected child abuse, when release is otherwise required by law, or when you request that I release information. Should the need arise, your case may be discussed anonymously during case consultation with another licensed psychologist while keeping identifying information strictly confidential.

PAYMENT OF FEES

It is customary to pay for professional services when they are rendered by cash or check made out directly to Pamela A. McCaskill, Ph.D. Unfortunately, I do not accept credit or debit cards at this time. If other payment arrangements are desired, please discuss this with Dr. McCaskill.

CHARGES

Charges for professional services are as follows:

Initial Clinical Interview (Therapy, first session):	\$225.00
Individual and Family Therapy (per 45 minute session):	\$145.00
Full Psycho-educational Assessment (varies by individual):	\$2175.00 – \$2625.00
Gifted Evaluation	\$400.00
School Visit or Legal Fees (per hour):	\$250.00
*Telephone Consultation (per 45 minutes):	\$145.00

*Individual session fees (prorated for time) apply to phone calls lasting more than 5 minutes.

INSURANCE

Many insurance plans cover all or part of the costs of psychological services. If you expect to file for reimbursement from you insurance company, I will, at your request, provide you with a suitable receipt on a monthly basis. Submission of forms or receipts to the insurance is, in all cases, the client's responsibility.

MISSED APPOINTMENTS

Clients are requested to provide a **24 HOUR NOTICE** of intention to cancel an appointment. Without such notice of intent to cancel, the missed appointment may be charged as professional time. Timing for your appointment begins at the scheduled time (in the unlikely event that Dr. McCaskill is running a few minutes over time with her previous client, the timing of your appointment begins at the time you are seen.)

Please indicate that you have read the above statements by signing below.

DATE: _____

CLIENT SIGNATURE

PARENT SIGNATURE (if applicable)

CLIENT NAME (Printed)

PARENT NAME (Printed)

SS#