Gregg R. Maynard L.C.S.W.
License # R-29575
212 North Prospect Avenue
Patchogue, New York 11772
631-475-2008

Information for my Clients

Welcome to my practice! Starting counseling is a major life decision and you may have questions. This document is intended to inform you of my office policies. If you have any questions or concerns please ask and I will try to give you more information.

APPOINTMENTS

Appointments are usually scheduled on a weekly or biweekly basis, typically on the same day and at the same hour. The therapist may request that sessions be scheduled less frequently, depending on evaluation during the course of the therapy. Therapy sessions are approximately forty-five minutes long. Unless using insurance, telephone sessions can be scheduled if you are unable to come to the office.

FEES

Your fee will be established at your first appointment. Payment is expected at the end of each session unless other arrangements have been made in advance. All services provided by the therapist are his time - therefore, telephone consultations, report writing and other services will be billed. Returned checks will carry a fee of $30

CANCELLATIONS

Since your appointment time is reserved specifically for you, it is important that you arrive promptly for your appointment. In cases where there is an unavoidable or medical emergency please call me as soon as possible. In other cases if you miss an appointment or you do not call to cancel at least 24 hours in advance, you will be charged 1/2 of the reasonable and customary rate for your missed appointment.

INSURANCE REIMBURSEMENT

Most health plans cover in part or in full the fees for our services. I will be happy to provide for you a bill for services on a monthly basis for submission to your insurance carrier. A $10.00 charge will be made to duplicate lost forms. Fees paid for psychological consultation and therapy may be considered a health expense for tax purposes. For more information, you may wish an income tax professional.

I, _____have read and agree to comply with the above provisions
Print name
of my treatment.

_____ _____
signature date

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Information about Insurance Carrier Disclosure and Confidentiality
HIPAA guarantees

Confidentiality is an important professional framework for counseling and psychotherapy. From time to time Insurance Carriers and /or Managed Care Plans request information about a client's diagnosis and treatment plan. Therefore, it is necessary to obtain beneficiary consent for the sharing of this information. This office follows all HIPAA guidelines as outlined in the Health Insurance Portability Act of 1996. This office has offered me a copy of the full HIPAA documentation.

I, _____hereby grant permission for the purpose
Print name here
of determination of medical necessity, the release of information about my treatment to my Insurance Carrier and/or Managed Care Plan.

_____ _____
Signature of beneficiary Witness

_____
today's date

Rev 3/08

Oceans Counseling Gregg R. Maynard LCSW
212 N Prospect Avenue Patchogue, New York 11772 631-475-2008 phone 631-475-2992 fax

Consent for Coordination of Care

_____ _____ _____
Print Name of Client Date of Birth Today's Date

I, _____, (client /guardian) give / refuse (circle one) my Consent for **Gregg R. Maynard LCSW** and _____(Primary Care Physician or health care provider) to exchange information regarding my medical treatment and mental health services. I understand that this consent will remain in effect for the duration of my care by Mr. Maynard, unless I request in writing its termination.

_____ _____
Client/Guardian Signature Name of Provider

_____

_____
Address

_____
Town Zip Code

_____
Phone/Fax Number

_____
Date sent