**Hannah Starobin, LCSW**

*138 West 25th St., 6th Fl. #20 125-131 East Main St., #207*

*New York, NY 10001 Mount Kisco, NY 10549*

**Office Policy Statement**

**Appointments and Cancellation Policy**

Appointments that are cancelled/not kept, for which you do not provide 24 hours notice will incur regular charges

**Fee Schedule and Payments**

Full payment is due upon receipt of services unless other arrangements have been made. Any collection, legal fees or cost necessary to collect unpaid balances will be the client’s responsibility. I accept credit cards, checks and cash.

A credit card number is requested at the initiation of treatment to ensure prompt payment. I will always inform you when I am billing your credit card and provide alternative payment methods if requested.

**Insurance**

I do not take insurances. However, a statement for insurance reimbursement will be provided to you as needed.

**Telephone and Email Access**

Due to the nature of outpatient practices, it may not be possible to respond immediately. If a situation requires an immediate response, please call 911 or go to the nearest hospital emergency room.

Email should be used, primarily for communicating logistical information. Clinical information and advice will not be sent by email.

**Credit Card Information**

Name on Card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Card Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type: \_\_\_\_\_\_\_\_\_\_\_\_ Expiration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Security Code:\_\_\_\_\_\_\_\_\_\_\_\_\_ Bill Zip\_\_\_\_\_\_\_\_\_\_\_

**I have read and agree to the above policies:**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_