Donna R. Steinberg, Ph.D.
Licensed Psychologist, NH #978
3 Lebanon Street. Suite 39
Hanover, NH 03755

Client Information Sheet

General Information: Office hours are by appointment only. My cell number is (802) 299-6359. I check for messages daily unless I am on vacation and have made other arrangements for coverage. If I cannot be reached in an emergency, please go to your local emergency room or dial 911.

Fees: Many health insurance policies cover a portion of the fee, but you are responsible for checking your coverage and submitting claims for reimbursement. Payment is expected at the end of each month unless otherwise arranged. Any phone sessions, whether regularly scheduled or emergency based, will be charged at full fee. You will be billed for every scheduled session unless you have cancelled or requested rescheduling at least twenty-four hours in advance of our appointed meeting time. If you exceed more than four missed sessions in a year, you will be billed for sick or scheduled absences.

Confidentiality: As a general rule, I will disclose no information obtained during your contacts with me, or the fact that you are my client, except with your written consent. However, there are certain limits to this rule of confidentiality. These limits are as follows: 1) when there is a suspicion of child or elder abuse or neglect, 2) when the client is potentially dangerous to self or others, and 3) when a judge determines that justice requires disclosure of clinical records. You should also be aware that if you are covered by a managed care program, that program may request clinical information about you before reimbursement is made or more sessions are authorized.

To insure the best possible treatment, I may discuss your situation with a consulting colleague. Your identity would remain anonymous and I will provide names of my consultants upon request. If you have concerns about this aspect of treatment, feel free to bring them up with me.

Agreement: I hereby authorize Donna Steinberg, Ph.D., to provide psychological services as she may deem reasonable for myself (or my child). I understand and agree to the policies described above. I agree to pay any charges incurred by me for such services. If for any reason and at any time, my insurance company construes such treatment as not being medically necessary and does not cover said treatment, I will be responsible for all charges.

Signature _____

Name _____ Date _____