Brianna Fava, Ph.D.

CANCELLATION AND FEE POLICIES

This policy statement has been prepared to prevent misunderstandings regarding your child's attendance and payment for sessions and consultations conducted by Dr. Fava and to insure the continuity of your child's treatment.

APPOINTMENTS
I understand that once my child begins treatment with Dr. Fava, he/she will have specific time reserved to meet with her, typically once a week for 45 minutes. If my child or I appear late for a session it unfortunately means that we will lose time from that session.

FEE
I understand that Dr. Fava and I will agree on starting fee for treatment. I also understand that Dr. Fava has the right to increase my child's session fee at any time by giving me verbal and/or written notice at least 4 weeks in advance of the fee increase.

PAYMENT
I understand that payment is due in full at the end of each session. If I fail to pay for two or more consecutive sessions, Dr. Fava has the right to stop treatment with my child and refer him/her to another appropriate treatment provider. I will pay by cash, check or credit card (Discover, MasterCard, American Express and Visa).

If I choose to pay by cash or check, I agree to leave a debit or credit card on file in the event that I delay payment for my child's sessions by 10 or more days from the date of service. In the event that my check is returned for insufficient funds, I understand that a $20 fee will be incurred.

CANCELLATION POLICY
I understand that a full fee is charged for cancellation for any reason, which includes, but is not exclusive to: illnesses, medical emergencies, child care conflicts, travel delays, and school demands. If my child has to miss a session, I or he/she will notify Dr. Fava at least 24 hours in advance call (631) 655-3021 in order to avoid incurring the charge of my session fee. ***If I do not give 24 hours advance notice, I understand that I will be charged for a full session.***

PHONE SESSIONS AND CONSULTATIONS
I understand that phone therapy sessions will be conducted only in emergency situations or under specials circumstances that have been negotiated and agreed upon between Dr. Fava and my child. In the event of a phone session, I will incur all long distance charges.

I understand that phone sessions conducted with my child, or phone or school consultations conducted at my expressed request with other professionals (e.g., my child's teacher or school psychologist), which I have provided Dr. Fava a written release of information to contact, are prorated and billed on the basis of my child's full session rate. I understand billing for these consultation sessions begin only after the first 15 minutes of the phone conversation or consultation and will be paid in full at my next treatment session.

I have read and reviewed Dr. Fava's cancellation and fee policies and agree to abide by them.
Printed Name
of Legal Guardian: ______________________ Name of Patient: ________________

Signature of Legal Guardian: ________________________ Date: ____________

☐ Patient has received a copy for their records on: ____________________
(To be filled out by Dr. Fava)