

Denise Fitzpatrick, M.Ed., LMHC
1350 Main Street
Walpole, MA 02081
617-694-7015

Policies & Procedures

Telephone & Emergency Procedures

If you need to contact me between sessions, please leave a message at (617) 694-7015 or e-mail to info@denisefitzpatrick.com and your call will be returned within 24 hours. If it is an urgent matter please indicate it clearly in your message. I check my messages regularly during the day and will make every effort to return your call the same day. Do not leave messages on my voicemail or e-mail if it is an emergency situation. If an emergency situation arises and you need to talk to someone right away call the Riverside Crisis Team: (781) 769-8674 or dial 911.

Cancellation/Missed appointment Policy:

Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (1 day) notice is required to re-schedule or cancel an appointment. You will be charged for appointments missed without notice or canceled with less than 24 hours notice, unless we are able to find a mutually agreeable time to reschedule the appointment within the same week.

Sessions

All Sessions are 50 minutes in length. Sessions end at 45 minutes past the hour to leave time for the scheduling of the next appointment. Telephone sessions can be scheduled if you are unable to come into the office and will be charged at the same fee. All copays must be paid at the time of service. There is a \$25.00 dollar fee for returned checks.

This page is yours to keep.

Denise Fitzpatrick, M.Ed., LMHC
503 Main Street
Medfield, MA 02052
617-694-7015

Policies & Procedures

Clients are asked to provide a credit card number which can be used for billing in the event of a late cancellation or no show.

Card Type (circle one): Visa / MasterCard/ Discover / American Express

Card #: _____ Expiration Date: _____ CVV Code: _____

Name as Printed on Card: _____ Billing Zip Code: _____

Authorized Cardholder Signature: _____ Date: _____

My signature below indicates that I have read and agree to the above policy statement and I agree to pay the fees as indicated.

Signature of client/ Date

Denise Fitzpatrick, LMHC

Date