Psychological Associates *of Clear Lake*

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FEE AGREEMENT

Initial _____X Our fees are $175 per therapy session or per hour of testing. Therapy sessions are for 45-50 minutes. Psychological testing services include actual time administering tests, test scoring, research, and report writing. Claims will be filed electronically on a weekly basis.

Initial_____X Responsibility for the fee is incurred when an appointment is made and the time is reserved for you. To avoid being charged, please call to cancel appointments 24 hours in advance. Late cancellations and missed appointments will be billed at regular fee. Insurance cannot be billed for missed appointments.

Initial______X There are times when insurance companies will not reimburse as expected. However, it is understood by accepting the services offered you are willing to pay regardless of your company's ultimate coverage. You agree to be responsible for checking and verifying your exact insurance coverage. If claims are not paid by your insurance company in 90 days, you agree to be responsible for payment. You always have the option of contacting your insurance company to inquire about claims filed on your behalf.

Please select an option below:

____ Option 1: (in-network PPO) I will pay my insurance copay at time of each service.

____ Option 2: I will pay full fee at time of service. If I have insurance I understand that my claim will be filed for me and that any benefits my insurance company allows will be paid directly to me.

I will pay for services by: ___credit card ___check ___cash

If you want us to file your claim for you please sign the box below.

<u>Assignment of Insurance Benefits</u>. HCFA insurance form box 12 and 13. Patient's or authorized person's signature. I authorize the release of any medical information necessary to process my insurance claims. I also request payment of medical benefits to my doctor for services rendered.

Signed____ Date ____________________

FEE AGREEMENT CONTINUED ON BACK

We require credit card information to be on file as a guarantee against unpaid balances. You may also use your credit card on file for recurring copays. We accept any of the cards listed below.

PRE-AUTHORIZED CREDIT CARD BILLING

I authorize Psychological Associates to keep my signature on file and to charge my account for any balances not paid for by insurance and for any late cancellations or missed appointments. I authorize recurring charges/copay amounts of $________ for each visit charged on my account. I have presented my card in person.

Patient Name ____

Name as on Card (please print) ________________________________

Street Address of Cardholder ______________________________ Zip __________

Account # ____

Expiration Date ______/_______ Security Code _______

Please Circle credit card company ____credit ____debit

Signature X ____

I HAVE READ THE ABOVE FEE AGREEMENT, HAVE ASKED ANY QUESTIONS THAT I MAY HAVE, AND AGREE TO THE TERMS DESCRIBED ABOVE. I HAVE REVIEWED A COPY OF THE HIPAA PRIVACY NOTICE AND COPY OF OFFICE POLICY AND PROCEDURES. I CONSENT TO RECEIVE SERVICES FROM PSYCHOLOGICAL ASSOCIATES. (If a parent, I consent for my minor child to receive psychological services).

Signature of Responsible Person X ____