

## FINANCIAL AGREEMENT

I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family where I am listed as the responsible party. I hereby agree to pay my insurance deductible and/or co-payment as services are provided. If for any reason there is a balance due on my account, I agree to pay promptly upon receipt of the monthly statement. I understand that Psych. & Psych. Services does not initiate billing to an insurance that is **secondary**. They only bill to the primary insurance company. I am responsible for activating & billing any secondary insurance coverage and for obtaining any necessary pre-authorization &/or treatment plan submission requirements for secondary insurance coverage. It is also my responsibility to review the Explanation of Benefit (EOB) forms I receive from my insurance so I can track insurance payment for services rendered.

I understand that my insurance claims will be sent electronically via computer modem to the Medical Payment Systems Incorporated offices. Medical Payments Systems will direct the insurance claim to my insurance company electronically where it will be reviewed by any insurance company staff assigned to review claims. I understand that my insurance company will obtain information listed on the insurance claim about my diagnosis and the dates of my mental health treatment sessions. By my signature below, and as recorded on the HIPAA consent form, I am giving Psych and Psych Services permission to release all data necessary to my insurance company to determine eligibility and to process my insurance claim electronically. I realize that my insurance company may choose to make this information available to other entities, including other insurance companies. Furthermore, I authorize that payment of mental health/chemical dependency benefits be made to Psych and Psych Services. Any questions that I have about confidentiality can be answered in the Notice of Privacy Practices found in the waiting room (abridged version is given to all clients). I have also signed the HIPAA acknowledgement form and understand my client rights and the rules regarding release of Protected Health Information. I have been informed that I can ask the Privacy Officer any questions regarding confidentiality of records, the complaint procedure, or other matters pertaining to my review of my record.

Although I have requested the office to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

**\*Certain special services (e.g. school psychological evaluations, report writing, some types of testing, court-ordered treatment/evaluation) are often not covered by insurance. It is the clients responsibility to determine what services are and are not covered by their health insurance. If you are being seen for any services other than psychotherapy it is strongly recommended you call your insurance carrier to verify coverage.**

**\*If you become involved in any legal matter that requires your therapist to testify in Court, or to prepare reports for your attorney or the Court, you will be charged \$100.00 per hour for these special services. These services will not be billed to insurance as they are not mental health therapy/evaluation services. YOU WILL NOT NECESSARILY BE REMINDED OF THESE SPECIAL CHARGES.**

I understand that charges will be added to my account for professional services rendered by my therapist (i.e., phone contacts over 5 minutes, preparation of special forms, reports, court time, etc.). The fee for these services is \$100.00/hour and is not covered by insurance. *The client will be reminded prior to the delivery of these services of the additional charges.* For Court-ordered Custody Evaluations the fee is \$130.00 per hour for all services.

I am aware that I will be charged **\$60.00** for each appointment that I miss or cancel less than 24 hours in advance. I am also aware that copays must be paid at the time of service. Failure to do so will result in a **\$5.00** charge in addition to the copay. I agree to pay this amount and I understand that these charges cannot be billed to my health insurance carrier. If I request a copy of my records I will be charged the rates listed in the Office Policies document I received.

In the case of default on payment of your account, collection costs and reasonable fees incurred by Psych and Psych Services in attempting to collect payment on your account will be charged to you. This will add **30%** to your amount due.

**I have read and understand the financial agreement as detailed above. By my signature below I agree to abide by the terms of the financial agreement, fully understand the release of information to my insurance carrier, and agree to make all efforts to pay for services rendered in a timely fashion. I am signing this agreement prior to receiving any professional services and understand that should I choose not to proceed with my initial session due to my finding the terms of this agreement unacceptable I will not be charged for the canceled session.**

**Signature:** \_\_\_\_\_ **Print Name** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_