Today's Date: _____

Client Name: _____
Date of Birth: _____
Address: _____
Apt./Unit# _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____

***FEE AGREEMENT

Billing will occur at the end of each month for psychological services at the rate of $170.00 per 45 to 50 minute session. [Other charges: $200.00 per hour for initial intake appointments; $200.00 for session 51(+) minutes, $200.00 per hour for assessment (including test scoring and interpretation, report preparation, and consultation): $10.00-$30.00 for records to be mailed out/released. Charges for legal consultation, testimony, and telephone consultation should be discussed with your psychologist.]

I UNDERSTAND THAT MISSED APPOINTMENTS THAT ARE NOT CANCELLED IN 48 HOURS IN ADVANCE WILL BE CHARGED A $50.00 FEE. THESE MISSED APPOINTMENTS CANNOT BE FILED WITH MY INSURANCE CARRIER AND I WILL BE HELD FINANCIALLY RESPONSIBLE.

_____ (Initials)

At your request, we will bill your insurance carrier directly. We cannot guarantee if or what your insurance will pay. It is the patient's responsibility to know what their outpatient mental health benefits are. The patient's share of the fee, including deductible, is due at the time of service. Whoever is specified as responsible for the bill must pay for all fees in the event of nonpayment or reduced payment by your insurance company. Parents of college students will be billed only after they have signed a fee agreement. Should your account become delinquent, your name and other information relevant to collects may be turned over to a collection agency. You will be responsible for all collection expenses, attorney fees, and court costs expanded in the resolution of the account.

I HAVE BEEN ORIENTED AS TO MY RESPONSIBILITES REGARDING MY FEE AND UNDERSTAND AND AGREE THAT I WILL BE RESPONSIBLE FOR PAYMENT OF THE BILL IN FULL.

Patient Signature: _____ Date: _____

Person Responsible for Payment Signature: _____ Date: _____

***TO ALLOW INSURANCE TO PAY OUR OFFICE

(We release only the Basic Minimum Information to your Insurance carrier in order to file your claim.)

I HEREBY ASSIGN ALL MENTAL HEALTH BENEFITS PAID BY MY INSURANCE COMPANY TO CLINICAL PSYCHOLOGISTS, PC THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. I HEREBY AUTHORIZE CLINICAL PSYCHOLOGISTS, PC TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

Patient Signature: _____ Date: _____

Person Responsible for Payment Signature: _____ Date: _____