Psychology CONSULTANTS INC.

PATIENT BILLING & PAYMENT AUTHORIZATION

PATIENT NAME:_____

Before your initial evaluation, your insurance company will be contacted to verify eligibility, co-insurance and co-pay's, when applicable.

Psychology Consultants, Inc. will bill your insurance company for any and all sessions. However, in the event that we cannot collect from them; you will be responsible for any or all of the billed amounts after each session. Psychology Consultants, Inc. accepts fee assignments with the insurance carriers of which we are contracted with; you will be responsible for the billed amounts of with which we are not contracted. When fees are not covered by your insurance, we will be pleased to discuss a payment plan.

It is understood that balances of 60 days and older will be subject to interest penalties at the rate of 1.5% per month, or 18% per year. It is also understood that the patient (or responsible party) is subject to assuming the responsibility for collection agency fees should it ever be necessary to send the account to collection. This fee is generally 50% of the balance on the account and will be added to the account balance should it become necessary. Also, should the balance on your account require legal adjudication, ALL court cost and ALL attorney fees will be the patients, guardian or parents responsibility. This includes the $ 65.00 NO SHOW FEE.

I have read and understand this information. I authorize my assigned therapist to release information necessary to process my insurance claim and authorize payments of such benefits to this office. I accept responsibility for any balances remaining after payments of insurance benefits.

I am aware that by making an appointment with this clinician, I am agreeing to abide by the billing policies of this practice. Should I not cancel and/or change my scheduled appointment within 24 hours of the scheduled time, I will be billed and agree to pay such a bill equal to what my insurance company allows for my session. I am responsible for this fee because no health insurance policies cover fees for missed appointments.

_____ _____

Signature of client (or person acting for client) Date