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FINANCIAL POLICY AGREEMENT

The following schedule summarizes our fees for service:

Intake Appointment:	$200/hour	(60 minute session)
Individual Therapy:	$165/hour	(45-60 minute session)
Family Therapy:	$165/hour	(45-60 minute session)
Psychological Testing:	$200/hour	(administration, interpretation/report writing)

Under the terms of the agreement, the patient or patient's legal guardian is responsible for full payment for services.

If you are utilizing health insurance benefits, we will be glad to submit your claim to your insurance company. **You will be responsible for paying any deductible and co-payments; these are due at the time of service.** If your insurance company rejects all or part of your claim, you will be responsible for paying the balance.

If your insurance carrier is a preferred provider or managed-care organization with whom we have a contractual agreement, fees will be governed by the terms of those contracts. **You are responsible for paying any deductibles and co-payments.**

If you are not using insurance benefits, **full payment is due at the time of service.** Private pay clients who pay at the time of service will be given a $30 per session discount as we do not have the cost of billing your insurance.

Cancelled or missed appointments with less than 24 hours notice are billed at one half the hourly fee and must be paid in full by the next session. This does not apply to appointments that are cancelled for illness or emergency.

It is agreed and understood that any charges incurred are the sole responsibility of the patient and/or the responsible party signed below. Any past due balance older than 30 days will be subject to a late charge of 1 1/2% per month. It is agreed and understood that if this obligation should become delinquent that you, the patient or responsible party, agree to pay collection costs, attorney's fees, and any costs associated with placing your account with a collection agency and/or an attorney for litigation.

I have read the policy statement and agree to these policies. I hereby guarantee payment of charges for psychological services and understand that should insurance fail to pay for this psychological treatment that I will be responsible for payment.

Signature _____Date _____