PSYCHOTHERAPEUTIC RESOURCES
TERMS OF BILLING/CONSENT

PATIENT COPY

- **Clients are responsible for knowing their insurance benefits and plan requirements. Therefore, if your insurance company does not pay (unless it was our error in billing or getting prior authorization) you are responsible for all charges incurred.**

- The fee for an assessment for an episode of care is $200. Ongoing therapy is $150 per session (45 minutes). Group therapy cost depends on the group and time commitment. Charges for psychological evaluations and testing vary; you will be informed of charges.

- **There is a $75 charge for non-emergency no-shows and/or cancellations made less than 24 hours in advance (unless there are rules that prohibit us from doing this). Therapists can waive this fee upon their discretion. These cannot be submitted to your insurance company. This must be paid prior to your next scheduled session. If there are repeated cancellations or no-shows the therapist may choose to discontinue care and provide referrals.**

- If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for all of his/her professional time, including transportation costs, even if he/she is called to testify by another party (fee for preparation and attendance at any legal proceeding is $200 per hour).

- If you are the parent who is authorizing medical care for your minor child but the other parent is legally responsible for medical payment, we will bill as requested. However, if we cannot secure payment with reasonable effort, we will expect payment from you (as the parent who authorized treatment). Therefore, if at all possible, we recommend that both parents authorize treatment.

- I will pay my co-payment of each visit and/or the total amount due.

- I will notify you immediately of any change in insurance company. Without such notification, any refusal on the part of my insurance carrier to pay for services because of needed preauthorization will be my responsibility.

- I consent to release of protected health information to **my insurance company or EAP group** for the processing of claims, care coordination and treatment determination needed to respond to the inquiry. I understand Psychotherapeutic Resources will give only the **minimal necessary information needed to respond to the inquiry.**

- If I am covered or believe I am covered by Medical Assistance (MA), I authorize this office to contact the county or counties as it relates to my MA number and coverage. I also authorize release of protected health information to MA for billing and prior authorization purposes.

- If my account becomes past due (60 days) and I have not arranged for or made regular payments, I understand Psychotherapeutic Resources may turn my account over to a collection agency and/or small claims court to obtain payment. My failure to make payments or arrange payments to settle my account is **tacit authorization** for Psychotherapeutic Resources to release the minimal protected health information necessary to the collection agency and/or small claims court.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Psychotherapeutic Resources. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. In signing this,
I am consenting to: 1) terms of billing
2) release of health information as needed for collection purposes
3) medical benefit assignment