



TERMS OF BILLING/CONSENT

You are responsible for knowing your insurance benefits and plan requirements. Therefore, if your insurance company does not pay you are responsible for all charges incurred.

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

The Fee for services is:

1st Session= Assessment/DA = \$275

Ongoing therapy is \$200 per session (45 minutes).

\$250 per session (60 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 \$100 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). 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.

We may require you to provide your credit/debit card information for us to keep securely on file so we can automatically charge any co-pays, co-insurance, deductible amounts, and professional service charges such as late cancellation or missed appointment charges. If a balance accrues and no payment is received, we reserve the right to seek payment using the credit card information we have on file.

You are responsible for keeping your credit card up to date and you will pay your co-payment of each visit and/or the total amount due at the time of the session.

If your account balance reaches \$400 or becomes past due (60 days) and you have not arranged for or made regular payments, you understand that Psychotherapeutic Resources may interrupt services and or turn your account over to a collection agency and/or small claims court to obtain payment. Your failure to make payments or arrange payments to settle your account is tacit authorization for Psychotherapeutic Resources to release the minimal protected health information necessary to the collection agency and/or small claims court.

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

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 possible, we recommend that both parents authorize treatment.

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

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 a valid as the original.

Please Initial that you have received a copy of the billing terms and consent: