Psychological & Counseling Associates

Dr. Belvia W. Matthews ♦ Dr. Calvin O. Matthews ♦ Dr. Lawrence R. Maier

PATIENT/RESPONSIBLE PARTY FINANCIAL AGREEMENT
PLEASE TAKE A MOMENT TO READ CAREFULLY

Welcome!

In order to make your transition as simple as possible, below are some policies that you will need to read and sign. Our office staff looks forward to serving you as a client .

1. All patients will need to bring the following items: **A CURRENT DRIVER'S LICENSE AS A PICTURE IDENTIFICATION, A MAJOR CREDIT CARD, AND AN UPDATED INSURANCE CARD.** If you do not have proof of insurance, you will be expected to pay in full at the time of service. The credit card information will be used only in the event of patient balances which are over 30 days past due. There will be an interest rate of 1.5% on accounts over 60 days past due. This charge will only be billed for the patient balance. Signature_____

2. **Office hours are 8:00 a.m. to 6:00 p.m. Monday thru Thursday, 8:00 a.m. to 12:00 p.m. on Friday. The office is closed daily from 12:00 pm to 1:00 p.m. for lunch. Summer hours are 8:00a.m.-5:00p.m. Monday thru Thursday, 8:00 a.m. to 12:00 on Friday (June-August)**

3. **In the event of an emergency, please contact the office. After hours calls will be charged according to length of call -1 to 25 minutes-$65.00, and 25 to 50 minutes-$130.00. During office hours our office staff will assist you with any questions or concerns that you might have. In the event of an emergency one of the therapists will be asked by our office staff to handle any phone calls or concerns. Signature_____**

4. You expect good quality service and the fees charged are comparable to those charged in our community for professional counseling services. The initial diagnostic session is $170.00 and the following sessions are $165.00. **All co-payments and fees are due upon arrival prior to your visit with the psychologist. Cash/Check/Credit or Debit cards accepted**. Signature_____

5. **I am aware that I will be charged a $100.00 fee for canceling an appointment without a 24 hour advanced notice or if I do not show up for my appointment**. **I am aware that this fee is not billable to insurance and that I am responsible for the entire fee of $100.00. Signature_____**

6. **I am aware that if I have repeat cancellations and or No shows that my therapist has the right to terminate services due to non-compliance with treatment and care.**

   Signature_____

7. **If you arrive more than 20 minutes late for your appointment without properly notifying the staff, you may be asked to reschedule in order to be considerate to the other patients which may arrived on time. Please be considerate. Signature_____**

8. I understand that I am <u>financially responsible</u> for all charges whether or not paid by insurance. If my check should be returned due to insufficient funds, I am responsible for a returned check charge of **$38.00 plus the amount of the original check**. Should collection proceedings become necessary, I agree to pay all costs of collection including a reasonable attorney's fee and waive all rights to claim personal exemption under Alabama state law. Signature_____

9. I am aware all co-payments are due at the time of service, at time of check-in. I am aware in order to request and receive release of records the patient balance must be zero. Signature_____

10. I am aware that authorization from my insurance company **does not** guarantee payment (especially for psychological). I am aware that <u>only a percentage</u> is paid by my insurance company for any assessment/evaluation/testing/psychotherapy and the balance is my responsibility. I hereby authorize the Doctors to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions. Blue Cross/Blue Shield patients please check specifically with your insurance company's payment schedule for psychotherapy/psychological assessment & evaluation as they do not provide preauthorization for testing and in many cases psychotherapy**. <u>*Please know the benefits of your insurance plan. If you have a deductible which has not been met, or your insurance deems your visit as a non-covered service, you are responsible for the balance. The terms of your insurance plan are between you and the insurance company. WE DO NOT DETERMINE YOUR BENEFITS OR PAYMENT TERMS.*</u>** Signature_____

11. If the Doctor has to appear in Court either by subpoena or by patient request the fee is $800.00 per day with a $400.00 deposit. Fees will be reduced accordingly if psychologist is not required for the entire day. The full court appearance fee is requested within 3 days of the court date. Signature_____

I have read and understand the above. If patient is a minor this is to be read and signed by the parent/guardian.

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Signature of Insured/Responsible Party Date

_____ _____

Witness Signature Date