

CAROLINA PSYCHOLOGICAL ASSOCIATES, P.A.

5509-B West Friendly Avenue, Suite 106

Greensboro, NC 27410

Telephone: (336) 272-0855

Fax: (336) 272-9885

FEE INFORMATION

Fees are an important issue to anyone receiving professional services. This fact sheet has been prepared to clarify our policies.

FEES: Our usual and customary fees are **\$140.00** for an initial intake, **\$120.00** per 50 minute session of psychotherapy, and **\$130.00** per hour for psychological testing. Fees for psychological testing are based on time spent with the client, *plus time spent for interpretation of results and report writing*. Payment is requested at the time services are rendered, by check or cash.

INSURANCE: As a courtesy, we file your insurance for you. However, the client is expected to pay for non-allowable and deductible charges, as well as co-payments, when services are rendered. If insurance payment is not received with **90** days, after a claim is filed, the client will become responsible for payment of the total amount due. **It is your responsibility to follow-up with your insurance company for delayed payments or other concerns.**

BILLING: We will bill clients monthly after insurance has been filed. This is a reminder of balance due and is an informational statement to keep you up-to-date regarding the status of your account. Our usual and customary collection procedures will be followed in order to collect unpaid balances and co-payments due.

REFUNDS ARE ISSUED ONCE A MONTH, ONLY AFTER ALL PENDING CLAIMS HAVE CLEARED.

PAST DUE ACCOUNTS: Processing past due accounts is expensive. Accounts which are over three months past due may be assigned to our collections attorney or small claims court, depending upon the total balance due, for enforcement of collection.

MISSED APPOINTMENTS: IF YOU ARE UNABLE TO KEEP AN APPOINTMENT, PLEASE NOTIFY OUR OFFICE IMMEDIATELY. IF AN APPOINTMENT IS CANCELED OR MISSED WITHOUT 24-HOUR ADVANCE NOTICE, YOU WILL BE CHARGED FOR THIS SESSION TIME. WE HAVE A 24-HOUR-A-DAY PHONE COVERAGE THROUGH OUR OFFICE AND AFTER-HOURS VOICE MAIL. INSURANCE DOES NOT PAY FOR MISSED APPOINTMENTS; THEREFORE, YOU WILL BE FINANCIALLY RESPONSIBLE FOR THE FULL FEE.

RESPONSIBILITY: The client (or referring parent in the case of minors) is considered responsible for payment of our professional fees. **It is the client's responsibility to know the amount of their deductible and/or co-payment.** When we are requested to bill a third party, such as a divorced spouse, relative, or insurance company, and that third party fails to make timely payments, payment is expected from the referring parent that signed the consent for services. The client will be responsible for claims that are denied due to "filing past the insurance carrier's time limit" that is the result of failure by the client to inform this office of changes in insurance coverage.

We appreciate the opportunity you have provided for us to be of service to you. If you have any questions, please discuss them with us. I have read, understand, and agree with the Fee Information guidelines outlined above.

Client (or parent) Signature
Fee.Form update 7/2003

Date

PLEASE READ AND SIGN

I, _____, give my consent for _____ to receive educational/placement consulting services from **Carolina Psychological Associates, P.A.** I understand and agree to pay **\$100.00** per hour for consulting services, **\$125.00** per hour for psychological testing, **\$300.00** for school placement research fee, **\$300.00** for a scholarship search fee, and **for any appointments that are missed or canceled less than 24 hours in advance. A \$20.00 fee will be charged for checks returned for non-sufficient funds. I understand that I am responsible for any fees incurred but disallowed for any reason by my insurance company, and for any agency fees/court costs involved in collecting on my past due account.** I understand that if I am unable to keep an appointment, I agree to notify Carolina Psychological Associates, P.A., with at least 24 hour advance notice. I agree that I am financially responsible for any phone calls longer than 15 minutes. Payment is required at the time services are provided; however, insurance information will be obtained at the first visit and insurance will be filed as a courtesy to me. Insurance will be filed for psychoeducational testing only!

Educational/placement consulting services may involve meeting with parents and/or the youth, reviewing educational, treatment, and medical records, and providing a minimum of 12 colleges (or 3-5 special needs program) for parents to visit and contact for their final choice. Parents and students are solely responsible for making the final choice of what they deem to be appropriate. Educational/placement consulting is not designed to be therapy or a substitute for therapy and treatment and cannot guarantee acceptance or the student's progress.

Release and Assignment: I hereby authorize any plan benefits to be paid directly to Carolina Psychological Associates, P.A., and I understand that I am financially responsible for non-covered services, including those for which authorization or payment is denied, either by EAP/Managed Care plan or payor. If a claim is made by me or by Carolina Psychological Associates, P.A., to any insurance company or companies, or to any third party payor, I do not object to the release by mail, fax, telephone or computer modem, any records or other information about my child, or the services which are provided, including, without limitation, the complete case record, information concerning any personal, psychological and medical history, information concerning the diagnosis and treatment by Carolina Psychological Associates, P.A., and information concerning billing and payment for such services. I agree that all such information shall be subject to review by such insurance company or third party payor during the period of my child's treatment by Carolina Psychological Associates, or at any time thereafter.

If the parents of this child are separated or divorced, and there is joint custody, I understand and consent to the other parents' notification of services of my child as advised by the N.C. Attorney General's Office.

Parent or Guardian Signature

Relationship to Minor

Date