CENTRAL PSYCHOLOGICAL SERVICES, LLC

mind·body·spirit

Payment Contract for Services

Client Name: _____ Date of Birth: _____

Address: _____

Bill to: _____
(Person or entity responsible for payment of account if not the client)

Address: _____

Insurance

Your health insurance may pay all or some portion of the cost of your treatment, depending on your coverage. Please provide the following information if you would like for us to submit charges to your insurance provider. Clients may be responsible for co-pays or non-covered charges based on their plan or deductible at the time of service. We do not accept secondary insurance. Please be aware that client(s) are ultimately responsible for payment of their account for the insurance reimbursable rate which may be subject to change.

Provide information regarding only your primary insurance.

Patient/Subscriber Name _____ Date of Birth _____

Identification # _____ Group # _____

Claims Phone # (Generally on the back of card) _____

Other Fees:

Non-covered services include all services not typically covered by insurance, and include services such as review of records, preparation of reports or letters for other providers/legal counsel/court orders, completion of documents for disability claims, consultations, etc. Please speak with your clinician if you have questions about these non-covered fees and charges.

Financial Expectations:

A fee equal to the cost of the clinical unit will be charged for missed appointments or cancellations with less than 24 hours' notice. Insurance will not cover these fees. Exceptions can be made for cancellations or missed appointments caused by medical emergencies, severe weather, car accidents, etc. These exceptions are at the discretion of your clinician.

If you experience problems in paying for your services at the agreed-upon rate, it is very important that you discuss this with your clinician as soon as is reasonably possible. Payments are due at the time of service unless otherwise agreed upon in writing. Delinquent accounts may be sent to a collection's agency. A 1½% per month (18% Annual Percentage Rate) interest charge may be applied to all accounts that are not paid within 60 days of the billing date. Delinquent accounts may be sent to a collections agency. There will be a $25 charge for checks returned for insufficient funds ("bounced checks"). By signing below, I agree to **all charges**, regardless of insurance coverage.

I give permission to release any information obtained during examinations or treatment of me/this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or me. I agree to pay any co-pay or non-covered covered expenses at the time of service. Payments may be made to your clinician or administrative staff by cash, check, or electronically.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of this Payment Contract for Services.

Person(s) receiving services: _____ Date: _____

Person responsible for account: _____ Date: _____
(If different from the person receiving services)

Clinician: _____ Date: _____

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