WESTHAMPTON FAMILY PSYCHOLOGISTS, P.C.

FINANCIAL AGREEMENT

Our fees for professional services are as follows:

- The fee for the ***Initial Evaluation is $150.00***.
- The fee for a ***45 minute therapy session is $125.00.***
- The fee for sessions exceeding 45 minutes will be assessed according to the amount of additional time spent in session. Insurance companies typically do not cover additional time beyond the 45 minutes therefore additional time will most often be paid out of pocket.
- The cost of a ***Psychiatric Evaluation*** and office visit with a Psychiatrist (MD) will vary depending on the length of the visit and nature of the appointment.
- ***An initial evaluation with a psychiatrist is $200.00***.
- ***The charge for a medication consultation is $75.00***.
- ***A medication evaluation combined with a therapy visit is $150 for a 45 minute session***.
- There is a charge for ***prescription refills and phone calls with the psychiatrist outside of a scheduled office visits.*** The amount will depend on the length of time involved.
- The cost of a ***Psychological Evaluation*** varies with the tests administered. Depending on your insurance policy, a portion of the charges may be reimbursable. Approval for reimbursement requires a separate pre-authorization which will be completed by the examiner prior to beginning the testing. Testing for educational purposes including achievement testing and assessments to rule out learning disabilities are **not covered** by insurance companies. A summary of individual testing charges is available and you may also feel free to discuss this with the psychologist. In addition to the charges for the evaluation, there is a separate fee for testing and scoring materials that is requested at the time of service. The amount of the charge will vary depending on the test materials used and is not covered by insurance companies.
- ***There is a $75.00 charge for all missed appointments***. A minimum of a 24-hour notice is required to cancel an appointment to enable us to reschedule the time with another person. Failure to cancel within this time or missing without canceling an appointment will result in a charge of $75.00 for which you are responsible. These charges cannot be filed with your insurance company and will be billed to you in full.
- There is no charge for brief ***telephone calls***, though calls regarding treatment or medication issues lasting more than 5-10 minutes will be pro-rated and billed at the regular hourly therapy rate. Insurance policies do not provide coverage for telephone therapy leaving you responsible to satisfy

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payment of any accrued charges.

- The fee for any requested ***court testimony*** regardless of whether the clinician is served a subpoena or requested by one of the parties is a minimum of $1200.00 for one half day (up to four hours) and $2500.00 for an entire work day. This includes time for transportation and preparation. Additional fees may be assessed if travel outside of the immediate area is required.
- ***Payment in full for court testimony*** is required 5 business days in advance of the scheduled hearing. In the event that a hearing is cancelled within less than 3 business days notice, a charge of $250 will be assessed. Responsibility for the payment in full for any requested court testimony is ultimately yours regardless of which party may have issued the subpoena. If you anticipate that your therapist will be needed in court, please ask us for a copy of our court policy for review.
- Some insurance companies provide what is referred to as ***"out of network" coverage***. In such cases, there is typically a deductible that must be met before the insurance company will provide payment for services. Once you have satisfied your deductible, your co-pay may be a specific percentage of the entire bill. Payment in full of this amount is your responsibility and is required at each office visit.
- ***Payment is due at the time of service for your portion of the bill***. This includes any portion of the bill that is not covered by the insurance company. We ask that prior to beginning services, you contact your insurance company to obtain any needed pre-authorizations and/or referrals. It is your responsibility to contact your insurance company to obtain information regarding the portion of the bill that you are responsible for. Payment in full of your co-pay is due at the time of service. Payment may be made in the form of cash or check. We also accept Visa and MasterCard as forms of payment. You are ultimately responsible for payment of all charges on your account even if your insurance company denies the claim or otherwise refuses to reimburse the charges. To avoid unexpected charges, we ask that you verify your coverage and note any restrictions or limitations prior to beginning treatment.
- ***There is a $25.00 charge for all returned checks.*** You are responsible for these charges.
- A ***service charge*** of 4% may be added to all bills that are 90 days past due. Failure to settle or make arrangements to settle your account will result in a referral to a collection agency. In addition to the sum of the bill, you will be assessed an additional collection fee of approximately 25% in addition to any legal or court fees.

I have read, been informed of and had the opportunity to discuss and ask questions regarding any and all of the above terms and I agree to accept treatment under them.

_____ _____

Date Name of Patient and/or Person Responsible for Payment

_____ _____

Date Signature of Patient and/or Person Responsible for Payment

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