CLIENT AGREEMENT-USE OF INSURANCE

___ I understand that Dr. Roberts is a provider for my insurance company which is: _____________________________
and that I am responsible for understanding the terms of my insurance policy.

___ I understand that I am responsible for co-payment for services rendered to me or my child/dependent and this is due on the day of service and that in the event that I become unable to make co-payments at the time of service, services will eventually be suspended until I am able to do so.

___ I understand that Dr. Roberts is a provider for my insurance company but that I am responsible for the full cost of services provided and for any payments not covered by my insurance company.

___ I understand that payments not covered by my insurance company including deductibles, copays, and non-covered services are due within 10 business days of my receipt of the bill, which will be mailed to my preferred mailing address.

___ I understand that therapy and testing appointments that cannot be kept should be cancelled with a minimum of 24-hours' notice and preferably more, in order to allow Dr. Roberts to serve others.

__ I understand that the first time I cancel my or my child or dependent's psychotherapy appointment with less than 24-hr notice or do not arrive for a scheduled appointment there will be no charge, but that for subsequent cancellations of less than 24 hours or unkept psychotherapy appointments, there will be a $100 charge out of pocket.

__ I understand that if I cancel with <24-hours' notice or do not keep my or my child or dependent's scheduled psychological or neuropsychological testing appointment there will be a $200 charge per hour of the scheduled appointment.

__I understand that if I or my child or dependent arrives late or leaves early from a psychological or neuropsychological testing appointment for any reason other than acute medical illness or emergency, the unused portion of the appointment will be billed at $200 per hour out of pocket.

__ I understand that if there is a balance for which I am personally responsible that exceeds $200 and is not paid within a reasonable time frame, treatment or evaluation services will be suspended until the balance is resolved.

_I understand that after 90 days, outstanding balances will be transferred to a collection agency.

__I understand that if my insurance changes, I am responsible for immediately informing Dr. Roberts of this fact and that I am responsible for charges incurred for any uncovered services.

__ I understand the terms of, and give consent to Dr. Elizabeth Roberts or her business associates to contact my insurance company to obtain information regarding my and my dependents' benefits ("Benefits Verification") for requested services. I understand that this contact is provided as a courtesy to me and that whether my insurance company covers provided services is at the discretion of my insurance company, and is reflected in my contractual relationship with my insurance company.

You have been provided the "Notice of Privacy Practices" and understand the limits to the disclosure of your protected health information.

- ☐ I give my consent for releasing minimum necessary information to the insurance carrier.
- ☐ I do not give my consent for releasing minimum necessary information to the insurance carrier.

Signature of Client or Guardian of Client ____Date _________
Print Your Name _______________________________________

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