CLIENT AGREEMENT:
Out of network services

I understand that (please initial next to each one):

___ Dr. Roberts is not a provider for my insurance company.

___ I am responsible for my bill.

___ Payment for testing and therapy and all other services is due on the day of service.

___ I am responsible for understanding the terms of my insurance policy.

___ Dr. Roberts or her business associates will do their best to obtain accurate information from my insurance company about pre-authorization procedures and coverage for any service including therapy and testing, but that it is my responsibility to understand the terms of my insurance policy.

___ Dr. Roberts accepts cash and checks.

___ Dr. Roberts will provide me with the necessary documentation for me to submit claims to my insurance company in accordance with out-of-network benefits procedures and will do her best to support that effort.

___ 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.

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

__ The first time I cancel my or my child's psychological, neuropsychological, or diagnostic evaluation appointment with less than 24-hours' notice or do not arrive for a scheduled appointment there will be no charge, but that for subsequent last minute cancellations or unkept appointments, there will be a $200 charge out of pocket.

___If an outstanding balance exceeds $200 and is not paid within a reasonable time frame, treatment or evaluation services will be suspended until the balance is resolved.

___Outstanding balances will be transferred to a collection agency after 90 days.

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

Your signature indicates that you understand and accept financial responsibility for treatment and understand the uses and disclosure of protected health insurance.

Signature of Client or Guardian of Client ____Date _________

Print Your Name ____

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