SELF-PAY BILLING AND COLLECTION POLICIES

Client Name: _____ DOB: _____

Professional Fees

- Initial Diagnostic Assessment $_250.00_____
- Individual or Family Therapy Session $_150.00_____
- Extended Therapy Session (75+ Minutes) $_200.00_____

Cancellation Policy

Once an appointment is scheduled, you will be expected to give 24 hours advanced notice of cancellation. There will be a fee for the missed session according to the following schedule:

- First No Show/Late Cancellation $_50.00_____
- Additional No Shows/Late Cancellations $_150.00____

Support Services

Initial phone calls made for case planning will not be charged unless the total time of the calls exceeds one hour. At which point, a charge of $_25.00_ will be incurred for each call lasting longer than 15 minutes. Other professional services, such as your request for my attendance at meetings with other professionals and preparation of records or treatment summaries, will be charged $_150.00_ per hour in 15-minute increments.

Payment

Payment for each session will be collected at the time of service. Hope Psychology Practice, LLC accepts cash, check, Visa, MasterCard, American Express, and Discover. We require you to leave your credit/debit card information on file for us to charge if payment is not received or additional charges are incurred. If you wish to pay via credit card, please be aware that Square sends receipts via email or text message. These receipts will include the business name, indicating that you are paying for psychological services. If you prefer not to receive such receipts, please pay via cash or check. All credit card charges will incur a _3%_ convenience fee. If an electronic payment is frozen or denied, you are responsible for ensuring that full payment is made by other means.

Outstanding Accounts

Our billing service provides monthly invoices if your account has a balance. If a balance accrues and no payment is received within 90 days of the date of service, Hope Psychology Practice, LLC reserves the right to seek payment by any means, including using the credit/debit card information we have on file, taking payment from family members whose information you have provided, retaining a collection agency, and/or taking legal action in court. If your outstanding balance exceeds the cost of three sessions, the therapeutic relationship may be placed on hold until the balance is paid. A letter reflecting this hold will be mailed to you if this occurs. If a payment plan is required, account balances between $1 and $499 will be charged at least $100 per month and account balances greater than $500 per month will be charged at least $150 per month.

Credit/Debit Card Information

I, _____, agree that my credit card information and signature may be kept on file and confidentially maintained to pay for services that are rendered by Hope Psychology Practice, LLC for _____ (client name).

Name on Card:	
Credit Card Number:	Expiration Date:
Billing Zip Code:	CVV Code:
Signature:	
Date:	

Agreement and Release of Information for Services
Please initial and sign the following:

_____ I have read and understand the above described agreement. After considering all options for payment of services, I agree to pay for services provided by Hope Psychology Practice, LLC out-of-pocket at the above rates.

_____ I understand the 24 hour cancellation and missed appointment policy and accept responsibility for payment as described above.

_____ I hereby authorize Hope Psychology Services, LLC to release information (i.e., the services received, the name of the person providing the services, the total charges for services, and the dates of service) to MB Billing Services, LLC in order to assist with my billing.

_____ I understand that no further information will be released without my advanced knowledge, except as authorized by law. I understand that I may revoke this consent at any time and that it will expire within one year of this date or when the purpose for which it was granted has been accomplished.

_____ _____
Client or Guardian Name Telephone Number

_____ _____
Client or Guardian Signature Date

_____ _____
Person Financially Responsible for Client Account Telephone Number

_____ _____
Payor's Signature Address