Psychological Associates
92 High Street DH7
Medford, Massachusetts
781-393-8889

FINANCIAL AGREEMENT

Patient Name: _____Date: _____

Insurance Carrier: _____ Tel. # _____

Subscriber: _____ Employer: _____

Subscriber Date of Birth: _____

Policy # _____ Group # _____

Authorization #: _____ Number of sessions: _____

Mail Claims To: _____

_____

Fees Schedule:

Initial Evaluation	$ _____
Individual Therapy (20-30 min.)	$ _____
Individual Therapy (45-50 min.)	$ _____
Family Therapy	$ _____
Psychological Testing	$ _____

Payment Policy:

Out-of-pocket payments and copayments are due at the time of service unless there is a special arrangement defined ahead of time.

Insurance payments are accepted per contracted fee schedule. Patients are responsible for co-payments and deductibles established by the insurer.

Signature _____ Date_____
(Guardian if patient is under 18)

Cancellation Policy:

I understand that I am personally responsible for the fee for any appointment canceled with less than 48 hours, or two business days notice. This fee is my personal responsibility and can not be billed to my insurance company.

Signature _____ Date: _____
(Guardian if patient is under 18)

Authorization to Release medical information:

I authorize the release of any medical or other information necessary to process insurance claims for services rendered to me, or to my dependents by Psychological Associates.

I also authorize payment of medical benefits to Psychological Associates for psychotherapeutic services rendered.

Signature _ _____ Date: _____
(Guardian if patient is under 18)

Responsibility to know your insurance benefits:

It is my (patient/parent or guardian) responsibility to know my insurance benefits. Therefore, I am responsible for any non-covered services rendered to my dependent or me. I agree to pay any co-payments, co-insurance, and deductibles as established by my insurer.

Signature _____ Date: _____
(Guardian if patient is under 18)

Authorization to Release Confidential Information:

I authorize Psychological Associates to disclose and make available information regarding my mental health status to my insurance company in written form or verbally for the purposes of reimbursement. I understand that this information may include, but is not limited to the following categories: clinical diagnosis; details of psychosocial history and description of my present functioning; dates of service, treatment plans and goals.

I recognize that Psychological Associates can not guarantee the confidentiality of my records when they are released to third party payers. I understand that this data may remain in a data bank that could be called upon at some future time when I apply for another health insurance policy, life insurance policy, or disability insurance policy.

Signature _____ Date _____
(Guardian if patient is under 18)