Wellness and Rehabilitation Psychological Services, PLLC
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Financial agreement and card authorization form: <u>In-Network</u>

I (*cardholder name*), _____agree to pay for all deductible, co-pay, or co-insurance fees that are assessed as my responsibility by my health insurance plan.

I understand that unless I provide a different form of payment, the card listed below will be charged for all deductible, co-pay and co-insurance fees, no later than 30 days after my health insurance company assesses them. In addition, I understand that the following fees are not payable by insurance companies and are my responsibility:

- Late-cancelled appointments (<u>less than 48 hours</u> in advance): $100 fee.
- <u>No show</u> appointments: a fee equivalent to the <u>full price</u> of the missed session will be charged.
- Late arrivals (more than 10 minutes late for a session): the difference between the typical insurance rate for the full session versus the actual insurance rate for the reduced session will be charged.
- Telephone calls for non-administrative matters lasting more than 5-10 minutes: charged on a prorated basis of $200 per hour.
- Other professional services taking more than 5-10 minutes, such as preparing letters in which clinical information is discussed, communicating with other health professionals: charged on a prorated basis of $200/hour.
- Court-related preparation and testimony: $450/hour
- Non-medically necessary services: e.g. performance coaching, or personal growth in the absence of a mental health disorder. Health insurance carriers will reimburse only for medically necessary services.

I understand that I am responsible for the full price of the sessions as follows if insurance refuses a claim:

- Initial intake session: $250
- Subsequent sessions (50-60 minutes): $200
- Subsequent sessions (30-45 minutes): $175
- Psychological assessment/testing: $250 per hour

I (*cardholder name*), _____ authorize payments to Wellness and Rehabilitation Psychological Services, PLLC as outlined in the fee schedule above. "ABH Account Services" (ABHAS) will provide the client with a statement of services, fees and payments on a monthly basis.

Card Type: □ Visa □ MasterCard □ American Express

Name on card: _____Relationship to client:_____
Card number: _____Exp date: _____3-digit security #:_____
Billing Address: _____

_____ Date: ___/___/____
Signature of cardholder