Weitman Psychological Services, P.C.
19995 S.W. Stafford Rd., Suite F
West Linn, OR 97068
Phone: (503) 684-1483
Email: garen@drweitman.com

Billing Information and Fee Agreement

Name: _____ Date of Birth: _____

Service Type	Time	Fees
Initial Telephone Consultation	15 minutes	No Charge
Intake Session/Diagnostic Interview	60 minutes	225.00
Individual Session	45 minutes	160.00
Individual Session – Extended	60 minutes	210.00
Family/Couples Session	45 minutes	180.00
Family/Couples Session – Extended	60 minutes	240.00
Group Session	80 minutes	60.00

Financial Policies:

Session Fees: Insurance companies will be billed, although you need to obtain initial authorization from your insurance company. I request each client to pay the fee and/or co-pay at the beginning of each office visit. You are ultimately responsible for your entire balance.

Additional Service Fees: In addition to appointments held in the office, other services that are billed at the hourly rate include reporting writing, telephone consultations other than administrative/scheduling calls, consultation with other professionals at your request, preparation of records or treatment summaries, and the time spent performing or attending to any other service that you may request of Weitman Psychological Services, P.C. If you become involved in any legal proceedings that require my participation, you will be expected to pay for all professional time, including preparation, travel time, and transportation costs, even if Weitman Psychological Services is asked to testify by another party. Because of the difficulty of legal involvement, the fee is $250 per hour, payable in advance. Weitman Psychological Services does not charge for infrequent brief phone calls (less than 10 minutes).

Insurance Reimbursement: If you are using health insurance benefits, you need to be aware of your policy and its benefits and limitations. All policies are different. All payments are due in full at the time of service until insurance coverage is confirmed. Otherwise, co-payments are due at the time of the session. Insurance payments will be applied to your balance. Positive balances are applied to future co-payments or refunded.

Late Fees: Please cancel all appointments within 24 hours so that your scheduled time can be used by others seeking services. You may leave a message on my voicemail, even after hours. If you choose to use email to cancel or reschedule appointments and you do not hear back from WPS, please call and leave a message. If you do not cancel within 24 hours, with the exception of emergencies, you will be charged 50% of your usual and customary fee the first time and 100% thereafter. The payment for the missed appointments will be due prior to or at the time of your next appointment, together with the fee for that appointment.

Delinquent Accounts: Please remember that you are ultimately responsible for your entire balance. In some cases, I will do monthly billing, showing all charges and payments for the past month until your balance is paid. All past due balances will

be charged 1% interest rate per month. Also, delinquent accounts may be turned over to collection agency, attorney, or court. The fee for returned checks is $50.00, or the bank charges, whichever is greater.

Payment Plan:

_____ I agree to pay the session fee or insurance co-pay in full at the time of service (cash or check)

_____ I request that my credit or debit card be charged for each session fee or insurance co-pay at the time of service

Credit Card Information

I authorize Weitman Psychological Services, P.C. to charge this account for services according to the financial policies and payment plan above.

Type of Card: □ Visa □ MasterCard □ Debit □ Discover
Account number _____ Exp Date: _____
Security Code _____ Billing Zip Code _____
Name of Card Holder: _____ Signature: _____
Address (if different than above) _____

Insurance Information (Please provide a copy of your insurance card(s) front and back):

Primary Insurance Carrier _____Phone: _____
Claims Address: _____
Name of Insured _____ Relationship to patient _____
Insured ID number: _____ Group Number _____
Insured Birth date: _____ Phone: _____ Employer: _____
Insured's Address: _____

- I understand the financial policies established by Weitman Psychological Services, P.C.
- I understand I am financially responsible for all charges, regardless of insurance, unless written by Weitman Psychological Services, P.C.
- I hereby authorize the release of all health care information necessary to process an insurance claim.
- I hereby authorize my insurance carrier to make payments directly to Weitman Psychological Services, P.C.
- I understand that balances left unpaid after 90 days from the date of service may be charged to my credit card.
- Past due fees may be referred to a collection agency to facilitate payment.

Client Signature: _____ Date: _____