**Jean M. Monty, PhD.**

**Psychological Services, LLC**

# Financial Agreement and Insurance Information

**Client name:_____ Date of Birth: _____**

## Agreement to Pay:

- I understand that I am financially responsible to JMPS for services rendered
- I agree to pay the co-pay, coinsurance, and any deductible stipulated by my insurance plan
- Payment is due at the time of my appointment unless other arrangements have been made
- It is my responsibility to inform JMPS of any changes that affect the billing or charges to my account. This includes third party payers, income, or family status.
- I understand that standard collection procedures will be followed if payment is not made.

## Standard Fees and Charges per session*

| | |
|---|---|
| • Mental Health Initial Evaluation | $200 |
| • Mental Health and Family Therapy, 38-52 minutes: | $160 |
| • Mental Health and Family Therapy, 53+ minutes: | $175 |
| • Mental Health, Group Therapy, 90 minutes: | $80 |
| • Psychological Testing, 60 minutes: | $225 |
| • Self-pay | $125 |

*If your psychologist is an in-network provider, she/he has agreed to accept the contracted rate with your insurance company.

*ADDITIONAL, PRORATED CHARGES MAY BE INCURRED FOR THE FOLLOWING: Phone calls of duration made by client or relatives, preparation of reports, letters, or handout materials, and consultation with collateral personnel (e.g., physicians, other service providers, legal counsel).

## Insurance Information

**Primary Insurance _____**

Insured's Name: _____ Insured's Date of Birth:_____

Insured's Policy #_____

Insured's Relationship to Client ☐Self ☐Spouse ☐Parent ☐Other

Address and phone number of Insurance Company:_____

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Insured's Employer:_____

Employer's Address: _____

If another person is responsible for all or part of the payment please indicate that person here:

Name:_____ Phone:_____

Address: _____

**Assignment of Benefits:** I authorize payment by my third party payer (Insurance Company, Medicare/Medicaid, County, or other) to be paid directly to JMPS for services rendered. I understand that I am financially responsible to JMPS for charges applied to deductibles and for all charges limited by my third party payer.

## Financial Policy

FEE PAYMENTS: Please understand that when you come for psychological services, you and your psychologist automatically contract with one another. While we will do our best to assist you in verifying insurance coverage, it is ultimately your responsibility to understand your benefits. Any charges not covered by your insurance company are your responsibility. This includes deductibles, co-pays, lapses in coverage, or any private pay arrangements agreed upon between you and your psychologist. Payments are due 30 days from the date of the statement. After three consecutive months, failure to make payment in full, or to make payment arrangements with our office, will result in your account being turned over for collections. If this occurs, a 25% collection charge will be added to your bill.

*If your psychologist is an in-network provider, she/he has agreed to accept the contracted rate with your insurance company.

*ADDITIONAL, PRORATED CHARGES MAY BE INCURRED FOR THE FOLLOWING: Phone calls of duration made by client or relatives, preparation of reports, letters, or handout materials, and consultation with collateral personnel (e.g., physicians, other service providers, legal counsel).

***Please read the following:***

- I understand that any no shows or late cancellations (less than 24 hours notice) will be billed at the rate of $50.00. I also understand that insurances companies will not cover these charges and I am therefore responsible for this payment.
- I understand that I am responsible for any charges not covered by my insurance company including deductibles, co-pays, and lapses in insurance coverage.

_____ _____

Signature of Individual Receiving Services/Legally Responsible Person Date

_Jean Monty_____ _____

Dr. Monty, Psychologist Date