INSURANCE AND FINANCIAL SUMMARY AND AGREEMENT

(If client is a minor, please have the financially responsible party complete this form as appropriate.)

Please initial each item as appropriate.

INSURANCE COVERAGE

_____I understand that this practice ***does not*** participate with my current insurance provider at this time and that I am responsible for payment in full at the time services are rendered. I also understand that I may be eligible for reimbursement for these services by my insurance company and that BPC&C will provide me with documentation of services rendered so that I may submit for any reimbursement for which I am eligible. I understand that I am responsible for contacting my insurance plan administrator with any questions I may have regarding submission requirements and coverage for psychotherapy services prior to my first visit.

_____I understand that, as of the date below, this practice participates with my current insurance provider.* I understand that I am responsible to make my full co-payment at the time services are rendered. I also understand that I am responsible to provide BPC&C with all information necessary to obtain pre-authorization for services and reimbursement for services rendered. I understand that I am responsible for notifying BPC&C immediately if my insurance coverage changes or lapses for any reason. I understand that if I fail to notify BPC&C timely of any change or lapse in my insurance coverage, then I will be responsible for payment in full for any services rendered during a lapse in my insurance or service authorizations.

**You must provide a copy of your current insurance card with the following information at your first appointment.*

Date of contact with your insurer:_____ Telephone number contacted:_____

First name of rep spoken to:_____

Does your insurance plan require pre-authorization for outpatient mental health services? □Yes □No

Did they give you a pre-authorization number? If yes, please provide:_____
If no, do they require that the provider contact them for pre-authorization? □Yes □No

Is there a limit on the number of outpatient mental health services you are allowed? □Yes □No

What is the amount (or percentage) of your copay for outpatient mental health services?_____

Is there a deductible that must be satisfied prior to copays kicking in? □Yes □No
If yes, what is the deductible amount? _____

Please initial here:_____

FEE SCHEDULE

_____I have read and understand the fee schedule for clinical services provided by BPC&C as listed below:

Type of Session	Length of Session	Fee
Initial Evaluation	60 minutes	$175.00
Psychotherapy-Individual Adult	50 to 60 minutes	$150.00
Psychotherapy-Individual Child or Adol.	45 to 60 minutes	$160.00
Psychotherapy-Couple/Family	60 minutes	$175.00

Psychotherapy-Group	50 to 60 minutes	$ 45.00
Telephone Consultation with client/family	Per 15 minutes	$ 30.00*
Inter-Disciplinary Telephone Collaboration	Per 15 minutes	$ 30.00*
Outside-Session Services (report-writing, court, non-reimbursable meetings)	Per hour (pro-rated)	$150.00

*at discretion of provider

PAYMENTS AND BILLING

_____I understand that I am responsible for payment for services rendered and that payment is due at the time of service by way of cash, pre-printed check, or credit card.

_____I understand that I may be required to provide credit card information to be kept on file to facilitate payment.

_____I understand that my credit card may be used to collect outstanding balances unless other arrangements are made in advance.

_____I understand that I will be charged an additional $25.00 fee for any returned check.

UNPAID BALANCES

_____I understand that long-standing or excessive balances may be collected through a collection agency or through other legal means.

MISSED APPOINTMENTS AND LATE ARRIVALS

_____I understand that, because the therapist has reserved time exclusively for my appointment, I am required to provide at least 24 hours prior notice to cancel an appointment. If I arrive late for an appointment, or if I fail to provide at least 24 hours prior notice, I understand that I will be charged the ***full session fee*** unless I am extended a courtesy at the sole discretion of my therapist.

_____ _____
Signature of Financially Responsible Party* Date

_____ _____
Print Name Relationship to Client

_____ _____
Print Client's Name (if different) Client's DOB

*If parents are **separated** or **divorced** and have **joint custody** of the client, then both parents' signatures are required.

_____ _____
Signature of Additional Financially Responsible Party Date

_____ _____
Print Name Relationship to Client