

Debra Haverson Psychotherapy Associates
P.O. Box 416/19 Green Ave 2nd Floor, Madison, NJ 07940

Agreement to Accept or Assign Financial Responsibility

Payment Information for: _____ (Client name)

Financially responsible party: ___ Self ___ Parent ___ Other

Please provide the following information about the Financially Responsible Person(s) **ONLY IF IT IS NOT YOU**

Name: _____ Date of Birth: _____

Relationship to client _____ Home phone: _____ Cell/Work phone: _____

Employer: _____ Occupation: _____

Billing address: _____

Please initial next to the most appropriate payment arrangement:

- MANAGED CARE IN-NETWORK Name of Insurance and policy name _____
- MEDICARE
- OUT-OF-NETWORK Name of Insurance and policy name _____
- PRIVATE PAY

Payment/Insurance Agreement & Authorization to Send Reimbursement Information

- I accept responsibility for payment of charges for services rendered to myself or the above-named person. I understand that full payment of _____ is expected at the time services are rendered unless the therapist agrees otherwise due to the arrangement with the behavioral health insurance company. In that case, I understand that a copay of _____ is due at time of service. If using out-of-network benefits, I have read and signed the attached addendum.
- I understand and agree that I may be charged for and required to pay for missed appointments not cancelled at least 24 hours in advance.
- I further understand and agree that a collection agency and/or the courts may be used in the event of delinquent payment, and I realize that such action could require that the therapist release to the collection agency, attorneys, and/or the courts, information which identifies the parties involved, gives the client's diagnoses, and describes the dates and nature of the treatment.
- I also understand that, in the event that my health insurance changes or its coverage and/or benefits are altered by me in any way, I shall be responsible for the unpaid amount should my insurance claims be denied. Pursuant to said insurance, I understand that I am responsible for informing my therapist of any coverage and/or benefit changes as quickly as possible and that my failure to do so holds me liable and responsible for direct payment to the therapist of any and all denied claim amount(s).
- This consent shall remain in effect until all outstanding balances have been paid in full.
- I am aware that services other than my psychotherapy sessions may be billed as additional out-of-pocket costs according to the fee schedule on page 2 of this agreement.

Signature of person who will be financially responsible for fee payment

Date

Note: If another party is paying for your treatment, they will need to sign this page even if you are 18 or older.

Debra Haverson Psychotherapy Associates
P.O. Box 416/19 Green Ave 2nd Floor, Madison, NJ 07940

Agreement to Accept or Assign Financial Responsibility
Page 2 Fee Schedule

The following services may be billed as additional costs due at the time of services and/or immediately upon receipt of invoice, by cash or check only. It will be the client's/insured's responsibility, not the therapist's to seek reimbursement, if any, from the behavioral health insurance company.

Flat hourly rate of \$110 per hour, with time spent determined in 15-minute increments for services such as:

- Collateral calls, correspondence, and coordination with school staff; psychiatrists; attorneys; officers of the court or criminal justice center; worker's compensation, disability claim, and auto insurance companies; and other medical/psychiatric treatment facilities.
- Status reports or psychosocial evaluations to any of the above-listed parties.
- Participation in team meetings, court appearances, mediations or other events at the client's request or by subpoena. Clients may also be charged for mileage, at currently accepted rates (e.g., \$0.555/mile) and road tolls.
- Therapist may consider negotiating flat-rate arrangements for such services upon request.

In cases where requests are made for patient records by parties other than for the behavioral health insurance company, reimbursement is expected for the costs of photocopying and mailing.