INSURANCE/PAYMENT AGREEMENT

My fees are meant to be fair and reasonable. I strive to keep them that way. You assist me in that effort when you pay for our services at the time of each visit.

I will cooperate fully with all clients who are covered by insurance for which I am a participating provider. Other clients may be requested to be more active in obtaining their reimbursement. Insured clients should read their policy carefully to become familiar with its benefits and limitations. It is important that you understand that in most cases your insurance is designed to reduce your cost, not to eliminate it completely. You are ultimately responsible for the full amount of your bill regardless of your insurance coverage.

Clients having insurance are expected to pay their co-pay at the time of service. Any difference will be billed or refunded to you after the insurance payment has been received.

If your account is outstanding for more than 30 days, a monthly service charge of 1.5% (18% year) will be added to the balance. If a payment has not been received for 60 days, your account will be turned over to my collection service and a 25% collection fee will be added.

Any checks returned to my office are subject to an additional fee of $25. Immediate remittance in the form of cash, money order, credit card, or certified funds is expected.

If at any time you have a question about this policy or your account, please do not hesitate to contact me.

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I have read the above policy and agree to accept the terms as stated. I authorize the release of any information necessary to process this claim. I authorize payment directly to Perette M. Halpin, LCSW-C, for the services provided. I understand that I am responsible for any additional fees incurred, as outlined above, or any unpaid balance.

_____ DATE:_____

SIGNATURE OF CLIENT OR LEGAL GUARDIAN

WITNESS:_____