COMPREHENSIVE COUNSELING CONNECTIONS, PLLC
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## PSYCHOLOGICAL SERVICES FEE AGREEMENT and CONTRACT

Welcome to our small group practice. This document contains important information about our services and policies and explains the evaluation procedures, professional fees, billing, and payment arrangements prior to seeing us. Please read this document carefully and ask any questions you might have prior to signing.

*Psychological Services:* We offer different assessments to diagnose, create treatment plans, and offer recommendations. Psychological testing can help answer questions about emotional and behavioral functioning, intellectual and memory functioning, and learning issues. Over a period of 4 to 12 hours, standardized testing procedures are followed to assess the referral question/s. Psychological testing services include interviews, self-reports, and tests. The hours you are billed may include the practitioner's time required for reading and reviewing records, consultations with other professionals (such as school personnel, medical providers, etc.), scoring of tests, interpreting the results, and any other activities to support the completion of your psychological evaluation.

Confidentiality: HIPAA (Health Insurance Portability and Accountability Act) and PHI (Protected Health Information) laws and ethical principles that guide mental health professionals protect the patient's privacy. In most situations, your information can only be released to others with your written consent. However, there are a few exceptions. In legal proceedings such as child custody cases or those in which your emotional condition is an important issue, a judge may order your clinician's testimony if s/he determines that it is appropriate. Your clinician typically will first assert their privilege to protect your confidentiality; however, a judge can override this attempt and order that records be submitted or that testimony be given.

There are situations where we have a legal obligation to take action to protect you or others from harm, even if information about your treatment is revealed. When there is suspicion that a child, elderly person or disabled person is being abused or neglected, we are required to take protective actions: such as notifying the potential victim; contacting the police, Division of Child, Youth and Family Services, or Bureau of Elder Affairs; and/or seeking hospitalization for you.

If a client is under eighteen years of age, the minor's parents have a right to information about their services, except drug and alcohol information, which is protected for patients aged twelve and older in the State of New Hampshire. It is our policy to provide both parents with general information about the work with minors. In the case of separated/divorced parents with joint legal custody, both signatures to this agreement are required prior to the start of services.

If you have any further questions about the purpose and potential benefits of a psychological evaluation, we will be happy to provide additional information during the first scheduled session.

*Fee Schedule and Billing*: Psychological testing sessions are billed at an hourly rate (50-minute hour). The hourly testing fee is **$150** per hour. In order for us to perform an evaluation, it is necessary to determine how your services will be paid for. If you have a health insurance policy, it may provide some coverage for the evaluation depending on your insurance plan. We will be happy to help fill out the preauthorization forms needed by your insurance company and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you are responsible for any uncovered costs. You may need to contact your insurance carrier to confirm the coverage prior to the start of this evaluation in order to prevent any delay in services. ***Your signature on this agreement indicates that you understand that our preauthorization for this evaluation is not a guarantee that your insurance company will pay for the entire evaluation and that you will be responsible for any services that are not covered by an insurance plan.***

Unless other arrangements have been agreed upon, the total unpaid balance will be due upon completion and delivery of any report. If payment arrangements are needed, a separate payment agreement will be needed and approved. Payment for services may be made by check, money order, cash, MasterCard or Visa.

CCC will provide you with an itemized invoice of services and payments made for your health record. If your account becomes delinquent, you will be issued a notice. If payment in full is not made within 60 days, your account will be forwarded to a collection agency. If such action becomes necessary, your name, demographic and financial information, and amount due will be released to the collection agency.

*Consent for Treatment and Payment*: I have received a copy of this fee agreement and fee schedule and fully understand the expectations for payment. I hereby authorize Comprehensive Counseling Connections, PLLC to apply for benefits on my behalf from my insurance company to cover services, in part or whole. I certify that the information I provided about my insurance coverage is correct. I authorize the release of any necessary information, including medical information, to my insurance company in order to determine benefits to which I may be entitled. If my insurance information changes during the course of treatment, I will immediately notify CCC.

Appointments: Our office hours range from 8 am-8 pm.. Should you need to cancel or change future appointments, a 48-hour notice is required except for Monday appointments which require cancellation by the Thursday prior to your appointment. You may call the office and leave a voicemail at any time to cancel your appointment. Also, you may respond to the reminder sent through our electronic scheduling service called Jituzu. Reminders are automatically sent two days in advance of your appointment; however, you are still responsible for the appointment time even if the reminder is not sent. Because your appointment time is reserved only for you and cannot be filled without sufficient notice, missed appointments or those cancelled fewer than 48 hours prior to the scheduled time will be billed to your account. Insurance does not cover any portion of the $60 fee for missed appointments or those cancelled without sufficient notice, and payment of such fees is required by you at or before your next scheduled appointment. No further appointments will be scheduled until your account is paid in full.

*Insurance Information:*

_____
Patient's Name

_____
Patient's Date of Birth

_____
Subscriber Name

_____ _____
Subscriber ID Number Subscriber Date of Birth

_____ (____)_____
Insurance Company Name Company phone number

_____
Insurance Company Address City State Zip Code

I consent to receive psychological services for_____
(Patient's name)

I have read and understand the Fee Agreement and Psychological Services Contract. My signature below indicates that I have read the information provided above, understand my responsibilities, and agree to abide by its terms.

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

I, the provider, have discussed the Fee Agreement and Psychological Services Contract with the patient and/or his or her parents/guardians.

_____ _____
Signature of provider Date

_____Original Copy kept with patient's medical record

_____Copy of document provided to patient/parents/guardians

Payment Agreement

I, _____, agree to allow the assessment provider named below to perform the following services listed in the steps below:

***Step One:*** The assessment provider will conduct a clinical interview.

***Step Two:*** To determine the costs covered by your insurance carrier the assessment provider will request a preauthorization for psychological/neuropsychological testing.

***Step Three:*** Your insurance carrier will inform you of the approved testing benefits in a letter within one week of request.

***Step Four:*** Your assessment provider will review and obtain your consent to this psychological/ neuropsychological evaluation. You will be asked to sign a payment agreement with your assessment provider before testing will continue.

***Step Five:*** You may need to provide your assessment provider with medical, educational, developmental records, or any information relevant to this evaluation.

***Step Six:*** Meet with your assessment provider for individual, face-to-face evaluation sessions. Your assessment provider will discuss the number of testing sessions and the amount of time required at each session. Normally individual evaluation sessions are 1 to 3 hours per session. Depending on the number of tests, your assessment provider will share the approximate time to complete this step.

Tests will be chosen that are suitable for the purposes of this evaluation. These tests will be given according to the standardized instructions and scientific guidelines. Because new questions may develop over the course of the testing, the assessment plan may change over the course of the testing battery.

***Step Seven:*** Your assessment provider will score and interpret findings. A formal evaluation will be written and presented to you at a scheduled evaluation review session which will take no longer than an hour. Approximately two to three weeks will be needed by the assessment provider to complete this final step. If additional time is needed, your assessment provider will discuss this with you. If there any time constraints, please inform your provider during the initial clinical intake appointment.

Billing and Payments

The fee for the above listed services will be $_____.

___I will pay this amount in full with this signed agreement.

___I will pay 50% with this signed agreement $_____ and the balance of

$_____ is due prior to the delivery of the assessment report.

The patient/guardian assumes 100% responsibility for all services, including any and all balances from pre-approved insurance coverage. I understand that the fee for these services will be $150 per hour. The total fee for services is listed above. The rate of insurance reimbursement varies according to individual insurance contracts and I understand that CCC will be reimbursed based on my own health plan benefits.

Though my health insurance may pay all or a portion for this evaluation, I understand that I am fully responsible for payment for these services.

My signature below indicates that I have read the information in the Psychological Services Fee Agreement and Contract and agree to abide by its terms during our professional relationship.

_____

Patient's Printed Name

_____ _____

Signature of patient {or parent/guardian} Date

_____ _____

Witness Signature Date

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