GERSH, HARTSON, PAYNE, HOFFMAN & ASSOCIATES, P.C.

Frank S. Gersh, Ph.D. ~ Brenda J. Payne, Ph.D., ABPP ~ Tricia Hoffman, Psy.D. ~ Jennifer Kauder, Ph.D.
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Financial Policies & Agreement

Welcome to our office! We ask that you carefully review the financial policy information contained below. The professional and support staff are happy to answer any questions you may have**.**

Payment Policy:

- We bill insurance as a service to our clients. Accounts are due and payable as work progresses, regardless of insurance coverage.
  Please note that the identified client must be present at appointment for insurance to be billed.

- It is the client's responsibility to determine the extent to which the health insurance plan will cover the cost of each evaluation and therapy**.** Some services and charges may not be reimbursable by health insurance.

- The client is responsible to pay in full at each appointment or to pay their deductible, copayment, and/or coinsurance if insurance is billed. We encourage all clients to contact their insurance company to determine mental health benefits.

- If a balance due remains on the client's account for 90 days, the account may be turned over to a collection specialist on the 91st day with a $50 service charge added. In special circumstances, we may be willing to set up a payment plan with a client to avoid sending the account to collection. It is the client's responsibility to ask if this service is available.

- In cases where a pediatric client's parents are separated or divorced, the parent who initially brings the client in will be the person billed and the person responsible for payment of the account. We will not bill a second party for services that have been provided.

Cancellation Policy:

- If the client is unable to keep an appointment, we ask for notification of 24 hours in advance in order to make that time available to other clients. Cancellations without adequate notice or cause (such as illness) will be billed to the client. The charge for your appointment being canceled without adequate notice or cause is **$75 per 45 minute unit**. Such charges are not covered by your insurance.

I have read the financial policies and I agree to accept responsibility for the above mentioned terms. I have also read and understood the policies and practices to protect the privacy of my health information. I have been offered a copy of this document for my records.

_____	_____	_____
Individual's or Parent's Signature	Individual's or Parent's Printed Name	Date
_____	_____	_____
Individual's or Parent's Signature	Individual's or Parent's Printed Name	Date