Dynamic Behavioral Consulting

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PAYMENT CONTRACT FOR SERVICES

Name of Client:
____

____

Street Address of Client   City   State   Zip

Name and address of person responsible for payment of services (if different from above):
____

Federal Truth in Lending Disclosure Statement for Professional Services
Part One: Fees for Professional Services / Self Pay Arrangements

I (we) agree to pay Dynamic Behavioral Consulting, hereafter referred to as "the office," a rate of $____________ for an initial session (defined as 60 minutes consisting of a clinical intake) and a rate of $___________ per each subsequent clinical unit (defined as 50 minutes for assessment, testing, individual psychotherapy, and relationship counseling). I (we) agree to pay a fee of $55 for missed appointments or cancellations when notice to the office is made less than 24 hours of the scheduled visit of if I arrive more than 15 minutes late for my appointment, which would constitute the need for rescheduling my appoint and result in a missed appointment without 24 hours notice. If payment is not received at the time of service, a late fee of $10 will be applied to your account. Payments may be made with cash or check. All checks returned for insufficient funds will incur an extra charge of $15.00.

Part Two: Clients with Insurance (Deductible and Co-payment Agreement)

This office has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services:

Estimated Insurance Benefits

1) $_______________ Deductible Amount (Paid by Insured Party)
2) Co-payment _________________%   ($___________/clinical unit) for first___________visits.
3) Co-payment_________________%   ($___________/clinical unit) up to____________ visits.
4) The policy limit is ________per year: ___ annual ___ calendar

While the office will attempt to verify the above amounts with the insurance company, it is suggested that you confirm these provisions with your insurance company. The person responsible for payment shall make payment for services which are not paid by your insurance policy, all co-payments, and deductibles. Your insurance company may not pay for services that they consider to be non-efficacious, not medically or therapeutically necessary, or ineligible (e.g., instances where you receive services not covered by your policy, the policy has expired, or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

Part Three: All Clients

Payments, co-payments, and deductible amounts are due at the time of service.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Signature(s) of Person(s) Receiving Services ____ Date _________________

Signature(s) of Person(s) Receiving Services ____ Date ________________