Eichenhofer Psychological Services, LLC

Financial Policy

To keep the cost of mental health services to a minimum, Eichenhofer Psychological Services has adopted the following financial policy. This policy applies to all clients and specifies responsibility regarding payment for services rendered.

Fees by Provider/Service

Master's Degree Therapist (LCSW)

$175.00 Initial Diagnostic Evaluation (55-60 min.)

$150.00 Subsequent Therapy visit (45-55 min.)

Psychologist (PhD)

$200.00 Initial Diagnostic Evaluation (55-60 min.)

$175.00 Subsequent Therapy visit (45-55 min.)

Miscellaneous Charges

There may be fees for other services, including telephone services, consultations with schools or medical personnel, preparation of reports for legal cases, or extensive copying of records. Please consult your therapist with any questions regarding services and fees.

Health Insurance

Health insurance is a contract between the client and insurance company, and is a vehicle to help pay for medical services. Please keep in mind that insurance companies DO NOT guarantee payment for services over the phone and you are ultimately responsible for any expenses incurred if your insurance does not pay what you anticipated they would. It is in your best interest to be aware of your outpatient mental health benefits before you come in for your first appointment. As a courtesy, we will submit claims to your insurance company if you provide us current insurance information.

Payment

All anticipated co-pays, deductibles, and visit fees will be collected at the time of service unless another arrangement is made with your therapist. We accept cash, check, credit and debit cards from Visa & MasterCard and Health Savings Account (HSA) cards. Payments can also be made online at our website: www.eichenhofers.com via PayPal.

Assignment of Benefits

(Your signature is required for the clinic to bill your insurance)

Since my health insurance may cover the cost of service, I hereby authorize Eichenhofer Psychological Services to release to my insurance company and/or associated professionals any information from my medical record which may be necessary to determine benefits payable under my policy. This information may be transmitted electronically. I authorize payment directly to Eichenhofer Psychological Services for the benefits otherwise payable to me for the amount which covers but does not exceed services delivered. I guarantee payment of all charges incurred for services rendered which are not covered by my insurance benefits.

Client/Financially Responsible Party: ____

Date: _________________________

Private Pay

If you will be paying for visits privately (not through an insurance company) clinic policy requires payment at time of service unless you have made other arrangements with your therapist. Acceptable methods of payment are cash, check, credit, debit, or health savings card from Visa or MasterCard. Please be prepared to make payment at the time of your visit.

Cancelled or Missed Appointments

Clinic policy requires 24 hours' notice for cancellation of any appointment. If cancellation is not received on time, you may be charged a reserved time fee which will NOT be covered by insurance. Additionally, if you fail to show for a scheduled appointment, the same charge applies. Payment of these charges is due on or before your next visit.

Failure to Pay

We provide confidential, compassionate and effective care to our clients. We adhere to the highest standards of ethical practice and serve your needs in good faith. In order to continue our services, we expect payment for services rendered in a prompt manner. If extenuating circumstances arise, please consult your therapist regarding acceptable payment arrangements. Failure to do so may impact scheduling further sessions until the financial situation is resolved. If it becomes apparent that a client does not intend to satisfy his/her financial responsibility, a collection agency or attorney may be contacted to pursue collection of the account. If a fee is charged to Eichenhofer Psychological Services for collection agency services it will be charged to the client's delinquent account.

I have read and understand the above financial policy.

Client/Financially Responsible Party: ____

Date: __________________________