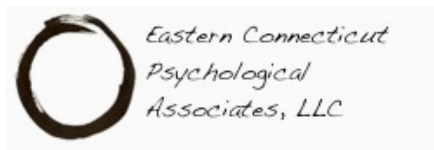

OFFICE PAYMENT POLICY

As part of our commitment to offer excellent medical and professional care to you and your family, we would like to present our office payment policy in order to minimize misunderstandings about fees. We ask for payment at the time of service. We commonly require payment at the time of check-in.

As a courtesy, we will file all applicable office charges with your insurance carrier(s). By your signature below, you authorize and request that insurance payments be made directly to your individual therapist. **However, you are ultimately responsible for all charges**. We advise that you familiarize yourself with the benefits of your plan. Prior to any services, we will assist you in determining your portion of the bill. This usually includes any un-met deductible, co-payment and co-insurance which are to be paid prior to the service. We accept Cash and Checks.

If you need an itemized statement to submit to your insurance, ask your therapist and they can provide one to you.

We are providers for several health insurance plans. You are responsible for your co-payment, deductible, or other non-covered services as set by your insurance carrier. Co-payments and deductibles are collected at the time of service. **If your insurance carrier requires a referral number to receive services form our office, it is your responsibility to contact your Primary Care Physician to obtain the number prior to your office visit.**

This policy is offered in an attempt to develop and sustain a continued professional and pleasant relationship. Your cooperation is greatly appreciated.

You will be charged the full amount of the visit for all missed appointments and cancellations without 24 hour notice. This is not payable by your insurance company and will be due at your next visit. We understand that emergencies and severe weather can prevent proper notice, and these cases can be discussed with your individual therapist.

CONSENT TO TREATMENT AND PRIVACY

I understand the above payment policies. I voluntarily consent to be treated by the therapist I have chosen or been assigned to work with in therapy. I affirm that I have been given no guarantees as to the results which may be obtained through treatment. Although it is generally recommended that I continue in therapy until the goals that we have agreed upon have been substantially achieved, I also understand that I may leave treatment at any time by my own decision I further acknowledge that I have been given the opportunity to review the Notice of Privacy Practices of Eastern Connecticut Psychological Associates, LLC.

Name of Client (Printed):______________________________

I have read and understand the above policies and consent to treatment.

____ Date ______________________

Signature

Relationship to Patient:__________________________