Diana Tumminia, LCSW - R

Payment Contract for Mental Health Services

Name(s) of client(s) receiving services:_____

Address:_____ City:_____ State: ___ Zip:_____

Person responsible for payment (if different):_____

Address:_____City:_____State:____Zip_____

A. Clients With Insurance Coverage:

I suggest you confirm your benefits and eligibility with you insurance company. The person responsible for payment is required to make payment for services that are not covered by your insurance policy (including all co-payments and deductibles).

Note: Your insurance company may not pay for services that they consider non-efficacious, not medically or therapeutically necessary, or ineligible (when not covered by your policy and when the policy has expired or is not in effect). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services and are not covered by your insurance will be discussed with the therapist. It is your responsibility to know if the therapist is accepted by our insurance for services reimbursement.

Some insurance companies require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While certain progress can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some plans also limit reimbursement to "in-network providers;" if you have such a plan, it is important that we review the plan to determine if coverage will be provided for my services.

You should also be aware that your contract with your health insurance company may require that I provide it with information relevant to the services that I provide to you, for which you seek coverage, the information that I can provide is Often limited to diagnostic information, including a treatment plan, the reasons for continuing treatment and the prognosis of how long the treatment will need to continue. If the insurance company determines that more information is necessary, the insurance company may request additional records in order to issue a determination about further services. This information will become part of the insurance company files and a subject to their use as for any medical record information.

Initial Here: _____x

B. Clients Without Insurance Coverage:

I (we) agree to pay Diana Tumminia, LCSW

a rate of $ _____ for 60 minutes of initial individual clinical assessment
Initial Here: _____x

a rate of $_____ for 60 minutes of initial couple/family clinical assessment
Initial Here: _____x

a rate of $_____ for 45 minutes of individual psychotherapy
Initial Here: _____x

a rate of $_____ for 45 minutes of couple/family psychotherapy
Initial Here: _____x

C. All Clients:

Payments and co-payments are due at the time of service. Any amount due on the client's account will be issued a statement showing the balance. Statement charges are due within 15 days. There may be an interest surcharge posted to overdue accounts which will be included on the statement.
Initial Here: _____x

I understand that I may not be seen for non-emergency behavioral health services if my account is past due and I have not entered into a Payment Plan Agreement with the therapist.
Initial Here: _____x

If I am unable to keep a scheduled appointment, I will notify the therapist as soon as possible but no later than 24 hours prior to my appointment**.** If I choose to not notify the therapist at least 24 hours in advance, or if I cancel my appointment less than 24 hours in advance, the therapist reserves the right to charge a full session fee paid by the client for each cancellation or no-show.
Initial Here: _____x

My signature below affirms I have read this form or it has been read to me; I understand the information and agree to these conditions.

Signature of Responsible Party	**Date**	**Relationship to Client**
_____x	**_____x**	**_____x**

Signature of Therapist	**Date**
_____x	**_____x**