Patient Number _____

Payment Contract

Effective August 31, 2015

This form outlines your rights and responsibilities with regard to payment for services received at Integritas Psychological Services, Inc. It includes a Federal Truth in Lending Statement and constitutes a contract for services.

Patient Name: _____DOB: _____

Address: _____

_____

Bill to Name: _____DOB: _____
(person or entity responsible for payment of account if not the patient)

Address: _____

_____

Federal Truth in Lending Disclosure Statement for Professional Services

____ I (we) agree to pay Integritas Psychological Services, Inc., hereafter referred to as IPS, a rate of $_____ for the 90- minute initial intake evaluation.

____ I (we) agree to pay IPS a rate of $_____ for a battery of psychological tests, including administration, scoring, and written report. I understand that, although the charge will be submitted to my insurance carrier for reimbursement, all or part of this charge may be rejected by my carrier (due to adjudicated lack of medical necessity or rejection of CPT codes), in which case I (we), agree to pay the balance.

____ I (we) agree to pay IPS a rate of $_____ per clinical unit (defined as 45 minutes) of psychotherapy, or $_____ per clinical unit (defined as 75 minutes) of psychotherapy.

____ Payment will be made at the time of service; weekly or for that month's provided and anticipated services. Payment plans can be made with the clinic to amend this provision.

____ A fee of $ _____ per clinical unit is charged for missed appointments or cancellations with less than 24 hours' notice . Exceptions can be made for cancellations or missed appointments caused by medical emergencies, severe weather, car accidents, etc. I (we) understand our insurance will not cover this fee and I (we) will be responsible to pay it.

____ Payments are due at the time of service unless otherwise agreed upon in writing. A 1 1⁄2% per month (18% Annual Percentage Rate) interest charge may be applied to all accounts which are not paid within 60 days of the billing date. Delinquent accounts may be sent to a collections agency and will incur a 3% or $50 collections fee, whichever is greater. There will be a $25 charge for checks returned for insufficient funds ("bounced checks").

____ Although IPS files claims for patients enrolled in some insurance groups, and complies with the contract and rates we have with those insurers, the patient is ultimately responsible for charges on their account and services rendered. Although an attempt will be made to contact me, should my balance not be paid, I submit the following credit card should other arrangements for payment not be made:

_____

Exp: ___/___ CSV _____ Zip code: _____

I have read and agree to the conditions in this Payment Contract and I understand I can receive a copy of this Payment Contract upon request.

Patient name (please print): _____

Signature: _____ Date: _____

Signed by: __ patient __ parent/guardian __ personal representative

Guardian name (please print): _____