Dr. Michael D. Smith, PsyD, PC

PAYMENT CONTRACT FOR PSYCHOLOGICAL ASSESSMENT

Patient Name: _____ Date of Birth:_____

Person Responsible for Payment of Account: _____

PART ONE - FEES FOR SERVICES ARE AS FOLLOWS:

- **Psychological Evaluation and Assessment for ADHD and Learning Problems** – For age 6-adult $1400.00 - 2500.00 ($700.00 deposit due on 1st day of testing), balance due the date assessment is presented. Assessments will not be released until full payment is received.

  Initial:_____

- **Attendance at School Meeting/Case Conference** - $150.00 per hour (minimum of 1 hour will be billed; travel time is also billed)

  Initial: _____

- **Legal Testimony/Preparation of Legal Documents** - $250.00/hour

  Initial: _____

- **Preparation of documents for insurance/FSA/HSA purposes** - $15.00 per document.

  Initial: _____

PART TWO - I (we) authorize Dr Michael D. Smith PsyD, PC to disclose billing information including but not limited to: diagnoses, dates of service, service provided, to third party payer or insurance company in order for the insured to receive reimbursement of payments made for services rendered

- I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments/benefits.
- I (we) understand that I (we) may revoke this consent at any time providing written notice.
- I (we) have been informed what information will be given, its purpose, and who will receive it.
- I (we) certify that I (we) have read and agree to the conditions of this document, and have received a copy if requested.

PART THREE – All Clients
Delinquent accounts that are past due by greater than 60 days may be referred to a collection agency**. A $45.00 fee will be assessed on all returned checks.**

MISSED APPOINTMENT CHARGE: In order to remain fiscally sound, this practice assesses the following charge for appointments missed:

- **$100.00 for missed therapy/intake appointment – less than 24 hours notice**
- **$125.00 for missed testing appointment – less than 48 hours notice**

I attest, through my signature below, that I understand and agree with the above payment policies.

Signature of Person Responsible for Account: _____ Date: _____

Signature of Psychologist or Representative: _____ Date: _____

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