Myers Park
Michele Mannering PhD
Pediatric Psychology

Patient Payment Responsibility and Agreement

Patient's Name:_____

Initial Each Below:

_____I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or my family members. I understand that payment is due at the time services are rendered unless special arrangements have been made.

_____Hourly fees have been discussed. Please contact the office for information on fees for legal cases.

_____Fees for Psychological Testing vary according to type of evaluation requested (i.e., Gifted, Educational, Emotional/Behavioral, Developmental, and Full Battery). The cost of the battery will be broken down for you accordingly. Please note that payment for testing is due at the time of the feedback session. **Completed reports will be provided upon receipt of payment.**

_____**All applicable fees must be paid at the time of service.** We do not file for any insurance, HMO or Medicare/Medicaid policies. We are considered an out-of-network provider for some insurances. We will provide you with a detailed statement you can submit directly to your insurance company for reimbursement.

_____Because time has been reserved exclusively for me and/or my family members, I understand that I am required to provide at least 24 hours advance notice if unable to keep the scheduled appointment. In the event that I do not provide 24 hours advance notice, I am financially responsible for the reserved appointment. We may make exceptions and waive the fee, at our discretion, for emergency or unusual circumstances. There may be a time when your therapist may need to cancel your appointment for an emergency; we will make every effort to reschedule you in an appropriate time frame.

I fully understand and agree to the above policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

Patient/Parent/Guardian Signature_____

Printed Name_____

Date_____