Johnson Neuropsychology – Payment Policy

We are pleased to welcome you to our practice. Our desire is to provide you with the highest level of psychological and/or neuropsychological care. **It is our policy to make financial arrangements with you before any treatment starts.** Below is an explanation of our payment policies. If you have any questions, please do not hesitate to ask.

1. Payment for services is due at time services are rendered. We accept cash and checks, debit and credit card (Visa, MasterCard, and Discover).
2. As a courtesy, we will file your insurance for you and accept assignment of benefits for your insurance if we are in your insurance's network. **Some insurance companies will not allow assignment of benefits to out of network providers.** In case, you are responsible for payment in full at time of service. We will still file the insurance for you upon request and your insurance will send payment to you.
3. **If the claim is not paid by your insurance carrier within sixty days, you will be responsible for the full balance and further insurance appeals become your responsibility.** We will be happy to provide you with a claim form so that you can follow up on your insurance claims personally.
4. **If at the time of the appointment you provide new insurance information that we do not accept, you will be responsible for payment of all fees.**
5. If insurance benefits are assigned to the practitioner, you will be responsible for paying your deductible and co-payments at the time of service. **You are responsible for paying all charges not covered by your insurance company.**
6. If your account balance remains unpaid after 60 days (two notices sent to you), this office will be required to employ a collection service to collect payment. The responsible party agrees to pay all related collection fees.
7. **The office cannot carry balances longer than 60 days,** regardless of whether the insurance payment is still pending. A finance charge will be added to your account if it is not paid within 60 days, regardless of the balance amount.
8. We offer 90 day (3 month) payment plans for those in financial hardship. We send monthly statements to notify you of any balance. This must be approved by staff so your account can be flagged so that it doesn't go into delinquent status.
9. There will by a $25.00 service charge on all returned checks. If the returned check is not paid within 10 days, it will be sent to the Denton County District Attorney's office.
10. **The parent or guardian who brings the child for their initial visit is responsible for payment independent of what a divorce decree states. Reimbursement must be made between the divorced parents—we will not intervene.**
11. Your appointment is reserved just for you. We require 24-hour notice of cancellation. **If canceling within 24-hour period of your appointment or if appointment is missed without notice to our office staff, you will be charged $50 for that appointment.** Cancellations for Monday appointments must be made by Friday at 4:00 p.m.
12. We require payment for the following additional services:
    - Telephone consultations are billed in [15] minute increments at our usual clinical rates.
    - Completion of disability forms, insurance reports, letters and other forms of written communication are billed in [15] minute increments at our usual clinical rates.
    - Legal consultations, report writing, correspondence and telephone contact for legal actions are billed at $300 per hour for all clinicians. Payment in full is requested prior to releasing the prepared letters and reports in legal matters.
13. You may request one copy of your medical record for yourself in accordance with HIPAA (Health Insurance Portability and Accountability Act) at no charge. All subsequent record reproduction(s) will cost $10 per copy.

I have read and accept the above Payment Policy. I understand and agree to the terms set forth regarding payment.

_____ _____

Individual Receiving Services (Patient) Date of Birth

_____ _____

Signature of Parent or Responsible Party Date

_____

Printed name of Parent or Responsible Party