Washington Psychological Services
87 East Maiden Street, Suite 2
Washington, PA 15301
Phone: (724)222.8575
Fax: (724)222.8545

Billing Policy

Patient Name: _____ DOB: _____

Insurance Coverage:

Due to frequent changes in insurance coverage (benefits, exclusions, deductibles, etc.) we cannot inform or advise you about your benefits. In some insurance policies, certain diagnosis are excluded. You are responsible for keeping track of number of visits allowed in your plan and how many visits you have used with your therapist and psychiatrist. You will be charged for additional visits. If you do not have insurance coverage, you are responsible for the full charges. Please inquire in advanced about our charges if you do not have insurance.

Payments:

It is our policy to collect all co-payments and/or deductibles at the time of service unless arrangements are made ahead of time. We accept cash and checks.

All delinquent accounts (over 90 days past due) may be turned over to a collection agency.

Cancellation/No Show Policy:

We understand that is not always possible to keep a scheduled appointment or give 24 hours notice of cancellation. If a pattern of same day cancellations or "no shows" develop, we reserve the right to bill you a $25.00 fee for the missed appointment time. Your insurance company is not responsible for this charge.

Returned checks:

Fee of $30.00 will be charged for returned checks for any reason.

"Red Flags Rule":

In accordance with The Federal Trade Commission regulation to protect consumers for identity theft, we may ask you to present photo identification with insurance card. This is effective November 1, 2009.

I have read and agree to be legally bound by the terms of this billing policy including the financial responsibility provisions hereof. I understand that I am financially responsible for any amount not covered or paid by my insurance carrier and that I am responsible for providing current insurance information and inform the office of any address and/or insurance changes.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Witness _____ Date _____