



PALMENTERA & ASSOCIATES, INC. SERVICE POLICIES

FEES: Our current fee is \$120 per session. The initial session is \$130 for adults and \$135 for children, adolescents, and/or families. Court-related cases are \$160 per session. The “intake process” is three sessions and is used to determine the clinical needs of each individual and the “fit” with the therapist. The duration of a session is 50 minutes which is known as the “clinical hour.” Payment is expected at the end of each therapy session unless prior arrangements have been made. Any changes in this agreement must be approved by your therapist.

ADDITIONAL CHARGES: We will charge for phone calls or preparation of insurance claims if they exceed 15 minutes and will be billed at the half-hour rate of \$60. Occasionally, scheduled session time will be devoted to filling out insurance forms in order to minimize costs, and to keep you fully informed of what is disclosed to your insurance company, this cost is not covered by insurance companies.

When psychological tests are administered, or if reports of any kind are prepared for another party or you, there will be an additional charge of \$150. If you are not sure if this applies to you, please ask your therapist.

Phone sessions will be billed at the standard therapy session rate in half-hour increments when they exceed 15 minutes.

There will be a \$33 charge for returned checks. A finance charge of 2% per month will be calculated on all balances over 90 days due.

MISSED & CANCELLED APPOINTMENTS: Since scheduling of an appointment involves the reservation of time specifically for you, missed appointments and cancellations less than 24 hours prior to the scheduled appointment will result in a charge for that time. Our phone is answered 24 hours per day and a message is sufficient notice during times when the office is closed.

FAILURE TO PAY YOUR BILL: Financial hardships may occur to any of us. These hardships should be discussed with your therapist, so that necessary changes in your payment agreement can be made. Non-payment may result in collection efforts or legal action. Of course, this is a regrettable action used only when other efforts have failed. If an account is sent to collection, you will also be held financially responsible for all collection fees assessed to our practice.

Some insurance carriers select a panel of providers to deliver therapy services and may not reimburse for services from other professionals outside their network. If you choose to pay for your services directly and submit your claim to your insurance carrier, we would highly recommend that you contact your insurance representative for pre-approval to confirm your coverage, and any limitations, including co-pays and deductibles.

CONFIDENTIALITY: Information revealed in your session is confidential and will not be released to others without your permission. There are some exceptions to this policy. If you were referred by your physician for a consultation, we may be requested to send information back to your physician so your complete physical and mental health can be coordinated. If your health insurance is a managed care program, they will request information so payment for services rendered can be approved. However, prior to disclosure of any information, you will be offered the opportunity to sign a release of information form. If you have concerns about this information, please discuss it with your therapist. Several legally required exceptions to confidentiality include situations of potential harm to oneself or others, incidents of child abuse (Ohio has a mandatory child abuse reporting law), incidents of elderly or dependent abuse and situations where a court may order records.



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PAYMENT AGREEMENT

As a client of Palmentera & Associates, Inc. I understand that I am financially responsible for professional services received by me or those for whom I am responsible. It is my intention to carry out my financial responsibility to Palmentera & Associates, Inc. in the following manner:

_____ I will pay for all professional services at the time they are offered. I will file my own insurance claims and request that Palmentera & Associates, Inc. provide me with statements and receipts.
(Note: All court-related services fall into this category.)

_____ Other (please specify) / Comments:

I understand Palmentera & Associates' Inc. service, fee and payment policies and agree to comply with these conditions. I understand all charges for services rendered are my responsibility.

Name of Client: _____

Date of Birth: _____

Signature of Client/Responsible Party: _____

Date: _____

Signature of Therapist: _____

Date: _____