PAYMENT POLICY____

Agreement to Pay for Professional Services:

I have been informed of the costs of services and understand that I am responsible for the cost of services should my insurance company not cover these services.

I understand that if I do not provide Lindeman & Associates Psychological Services, LLC with ***all*** of my insurance information, it is my responsibility to contact my insurance company for payment and that I will be responsible for payment to Lindeman & Associates Psychological Services, LLC.

I understand that Lindeman & Associates Psychological Services, LLC will file my insurance claims as a courtesy service and authorize my insurance benefits to be paid directly to Lindeman & Associates. I understand that if my insurance company does not pay my claim within 45 days, the balance will be billed to me.

I am aware that some and perhaps all of the services that I receive may be non-covered services, not considered reasonable or necessary or may be excluded from my insurance plan and understand that I must pay for these services in full at the time of visit.

I understand that it is my responsibility to contact my insurance company to determine my coverage of mental health services.

I understand that I will attend each scheduled appointment. If I am unable to attend, I will **call to cancel the appointment within 24 hours**. I understand that I will be **charged full session fee and I will be responsible for this charge** if my appointment is not cancelled within this appropriate time frame. **This does not apply to clients with Indiana Medicaid.*

All co-pays and deductibles are due at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. If you are uninsured and are receiving services, we require payment in full at time of service.

Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you or your immediate family members may be discharged from this practice.

My signature below indicates that I understand and agree with all of these statements:

Signature of Client:_______________________________________Date: ________________________

Or Legal Guardian

Signature of Therapist/Psychologist:___________________________________Date:_____________________________

Payment Arrangements:

☐ I give Lindeman and Associates permission to charge my credit or debit card if my account has a balance over 90 days past due, including missed appointment fees. * This information will be kept in a locked confidential file.

Credit Card Number: ____ SEC:____________

Expiration Date: _________________ Name on the Card ____________________________

Signature of Printed Name on Card ___________________________________ Date: __________

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