LINDEMAN & ASSOCIATES
Psychological Services

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. _____(initial)

I understand that if I do not provide Lindeman & Associates 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. _____ (initial)

I understand that 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. _____ (initial)

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 or establish a payment plan. _____ (initial)

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

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. _____ (initial)
**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. _____ (initial)

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. _____ (initial)

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

Signature of Client_____Date_____
Or Legal Guardian

Signature of Psychologist_____Date_____
Or therapist

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Payment Arrangements:

☐ I give Lindeman & 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 #_____

MasterCard_____Discover_____VISA_____American express_____

Exp. Date _____3 Digit code_____

Printed Name_____

Signature_____Date_____