Jessica Conwell, PsyD
Licensed Psychologist

Fee Agreement

Client name_____

PLEASE INITIAL EACH LINE BELOW indicating that you understand:

_____ The charge for the initial appointment is $200 and ongoing therapy services will be billed at the rate of $150 per 50 minute session.
_____ Preparation of reports or letters will be billed at the regular session rate, calculated on a prorated basis.
_____ Consultation is billed at the regular session rate. This includes travel time and telephone consultation.
_____ Case management which includes calls, letters and or emails to coordinate your care with physicians, dieticians, psychiatrists, school or anyone else you have authorized me to communicate with about your care will billed monthly on a prorated basis.
_____ Assessments will be billed at an agreed upon rate of (If applicable):_____

____Missed appointments will be billed at the full session rate if I do not give 24 hours notice of cancellation and this missed session fee will be charged to my credit card provided below unless other arrangements are made.

_____ Payment - I agree that payment is due at the time of service and that I am responsible for payment. Denial of payment by an insurance carrier or other third party, regardless of the reason, does not waive my responsibility to pay.

Please initial ONE of the two options below:

_____ I will pay for each session in full or the co-payment at the time services are rendered by check or cash. I understand that my credit card will be charged for any payments that are outstanding for 30 days or more.

_____ Charge my credit card for each session fee or co-payment at the time of service.

In addition, bill my insurance carrier. (Please fill out an insurance information form.)

If applicable, please initial the appropriate option below

_____ Please bill my insurance on my behalf. I authorize any balance outstanding 90 days after billing to be charged to my credit card. **If insurance payment results in a credit balance to my account with Jessica Conwell, PsyD, P.C., that credit will be refunded to me by check within 30 days of receipt by Dr. Conwell.**

_____ I will pay in full at the time of service. Please bill my insurance carrier on my behalf or provide me with a statement to submit to my insurance company for reimbursement. **If insurance payment results in a credit balance to my account with Jessica Conwell, PsyD, P.C., that credit will be refunded to me by check within 30 days of receipt by Dr. Conwell.**

Credit Card Information - (This is REQUIRED of all clients but will only be used as indicated above according to the payment option you chose or to satisfy an outstanding balance. In the case of an out standing balance, your card will not be charged without attempts to communicate with you first.)

I authorize Jessica Conwell, PsyD, P.C. to charge this account for services according to the payment plan agreed to above:

Card Number_____ Expiration Date _____ Three digit security code:_____

Type of card (please circle one): Visa/MasterCard
Card holders Name:_____Card holders Signature:_____
Billing address of card holder (street and zip code, if different from client): _____

I understand the terms of the payment plan and agree pay for services rendered by Jessica Conwell, PsyD in the manner agreed to above.

Signature of Client or guardian _____ Date _____