MARCIA JOHNSTON WOOD, Ph.D.
Clinical Psychologist

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FEE AGREEMENT AND INSURANCE INFORMATION

Client _____ Date of Birth _____

Fees are $225 for an initial 1 hour intake/consultation session and $160 per 45 minute standard session. Fees should be paid at the time of session unless another arrangement is agreed upon ahead of time. I am happy to accept cash or a personal check but do not take credit, HSA, or any sort of debit cards.

Please answer #1 regarding Medicare, *and also check* whether #2 Self-Pay *or* #3 Insurance:

1) MEDICARE: Are you covered by any aspect of Medicare? Yes _____ * No _____
* If Yes, please be aware that I do not take Medicare and by law you will need to sign an additional Private Pay Contract with me which covers that circumstance.

2) SELF-PAY: ____ I agree to pay in full at the time of service. *

* Exception: If we have agreed on this, the fee for treatment will be $_____ per session. I agree to pay at a minimum rate of $_____ per week/month until the balance is paid in full.

3) INSURANCE: ____ The following information must be completed and verified before treatment starts. It is important for me to estimate what your insurance, if any, will cover and for what length of time. This may affect our treatment goals and the frequency of treatment, which must be appropriate to your needs.

Name of Person Insured _____ Insured's Date of Birth _____

Subscriber I.D. # _____ Group # _____

Client's Relationship to Insured _____

Insured's Address _____

Insured's Home Phone _____ Work Phone _____

Insured's Employer _____ Effective Date of Coverage _____

Primary Insurance Co. _____ Phone _____

Is there another insurance co. or entity who specifically manages your mental health benefits?

Yes_____ No _____

If so, please provide phone: _____

Address to send Mental Health Claims *(may be different from other medical claims)*:

_____

Is your renewal period on the calendar year or a different cycle (please specify)? _____

Number of visits per renewal period _____

Have you used any of your mental health visits in this time frame and if so, how many? _____

Annual Deductible $_____ Remaining? _____ Copay required per visit $_____

If you need preauthorization have you done this? _____ Preauthorization # _____

Is my fee within your insurance company's fee range? Yes_____ No * (specify)_____

* Sometimes my fee exceeds your insurance company allowance (their "UCR"), in which case you will need to make up the difference between their allowance and my fee.

If applicable, please be aware that most insurance plans do not cover marital or couples therapy. Does your insurance cover marital or couples therapy? Yes _____ No _____

Do you expect your insurance benefits to change in the near future? If so, please explain: _____
_____
_____

In many cases, after the initial consultation session, I will bill directly to your primary insurance for the portion they will cover, but it is *your* responsibility to bill any secondary insurance you may have. In most circumstances, because of the delay in reimbursement, I request that you pay directly at the time of service for costs not covered by your primary insurance. If needed, you will be provided with a bill that you can submit to your secondary insurance or a flex or health savings plan.

Note: If you are a month behind in payment, no further sessions will be scheduled until the balance is paid or unless we have agreed to a different payment schedule. Failure to pay your bill can result in use of a collections agency or small claims court. You are responsible for reasonable collection and legal fees that result due to your failure to comply with the above agreement. Balances over 90 days are subject to such actions.

I have read, understand, and agree to the terms of this form. By signing this form I authorize the use of the signature(s) below on all insurance submissions and also authorize the payment of medical benefits to Marcia J. Wood.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Parent or Guardian Signature if Minor Date

(Revised 12/18)