JOHN W. FISHBURNE, PH.D.

PSYCHOLOGIST

SERVICE AND PAYMENT AGREEMENT

FEES FOR SERVICE – I, _____ (Please Print Name), understand that:

- Initial Intake sessions (90 minutes) are billed at $255.
- Psychotherapy sessions (55 minutes) and any extra written documentation are billed at $175 per hour.
- Psychological testing and assessment services are billed at a rate of $175 per hour up to $1,750.
- **Missed or Late Cancelled appointments will be billed at the full rate if I do not provide 24 HOUR NOTICE.**
- I agree that payments for services are due at the time of service and the responsibility for payment is mine.
- Denial of payment by an insurance carrier does not waive my responsibility to pay.

PLEASE SELECT FROM THE FOLLOWING PAYMENT OPTIONS:

☐ **THIRD PARTY FOR NEURO-PSYCHOLOGICAL TESTING:** _____

- I UNDERSTAND THAT THE PAYING PARTY RECEIVES THE REPORT FOR PSYCHOLOGICAL TESTING.

☐ **PRIVATE PAY (REQUIRED FOR PSYCHOLOGICAL TESTING AND ASSESSMENT)**

- I understand that this account is solely my responsibility and WILL NOT be submitted to an insurance company.
- I ASSUME FULL AND PRIMARY RESPONSIBILITY FOR MY ACCOUNT
- I intend to pay in full for the session at the time services are rendered.
- I agree that my credit card will be charged for any payments 30 days in arrears.
- PLEASE SUPPLY CREDIT CARD INFO AT BOTTOM OF PAGE.

WE DO NOT BILL MEDICARE IN ANY WAY! IF YOU HAVE MEDICARE. YOU WILL BE BILLED PRIVATE PAY.

☐ **INSURANCE SUBMISSION (BILLING OF YOUR INSURANCE COMPANY IS OFFERED AS A SERVICE. HOWEVER, THE RESPONSIBILITY OF PAYMENT ON THIS ACCOUNT REMAINS WITH YOU.)**

- I understand that this account is solely my responsibility and WILL be submitted to an insurance company.
- I understand that insurance companies require a diagnostic code for billable treatments (if you have questions about this, feel free to speak with your therapist). L&I requires regular progress reports and treatment updates.
- I agree to pay my estimated copay at the time of service and authorize that my credit card be charged for any client amount owed that is 30 days in arrears.
- PLEASE SUPPLY CREDIT CARD INFO AT BOTTOM OF PAGE. **L&I CLAIM #**_____

'15 Form Update

WE STRONGLY RECOMMEND THAT YOU CONTACT YOUR INSURANCE COMPANY AND CONFIRM YOUR OWN POLICY COVERAGE FOR OUTPATIENT MENTAL HEALTH SERVICES *PRIOR* TO YOUR FIRST SESSION.

INSURANCE COMPANY: _____ INSURANCE COMPANY PHONE #: _____

POLICY #: _____ GROUP #: _____ SS #: _____

CLAIMS ADDRESS: _____

POLICY HOLDER'S NAME:_____ Birth Date_____

RELATIONSHIP TO CLIENT: _____ SELF _____ SPOUSE _____ PARENT _____ OTHER

CREDIT CARD INFORMATION

- I authorize John W. Fishburne, Ph.D. to charge this account for services according to the payment plan agreed above: **Card Number XXXX-XXXX-XXXX-**_____ (Last 4 Digits)**.**

DATE:_____ SIGNATURE:_____

CREDIT CARD INFORMATION: This information will be shredded once it is electronically stored and protected.

Card Number _____**V/MC Expiration Date: (Mo/Yr)**_____ **3-digit CDI**_____