Raja M. David, PsyD, LP, LLC
Financial Contract

Patient Name ______________________________________ DOB _______________________

Street address ____

City _______________________________ State ________ Zip __________________________

Phone (H) ___________________ (W) ____________________ (Cell) ____________________

Please indicate preferred phone number.

Emergency Contact _______________________________ Phone # _______________________

If client is a minor, parent/caretaker name(s): ____

I am an out of network provider, but most services can be submitted for out of network reimbursement if you so choose. Under the terms of this agreement, the patient or patient's legal guardian is responsible for full payment for services at the time of service.

I will provide a Super Bill that contains all of the dates of service, billing codes and other necessary information that you can submit directly to your insurance company. Your insurance company will send any payments to you. Psychotherapy clients will receive a monthly bill and testing clients will receive it with the final report or Therapeutic Assessment letter. It is your responsibility to check with your insurance company about out of network coverage and whether the services rendered and billing codes on the following page will be reimbursed. I can make no guarantees that you will be reimbursed any funds from your insurance. A guide for out-of-network reimbursement is available if you have not already received it.

Psychotherapy Clients

Clients engaging in psychotherapy will typically first participate in an initial Diagnostic Assessment, followed by therapy sessions, which are most often 45 minutes in duration. Sessions will be billed via credit card (see below) following each appointment at the rates listed.

Testing/Assessment Clients

Clients engaging in a diagnostic assessment only or traditional psychological evaluation or a Therapeutic Assessment will be quoted a flat rate after the initial session or phone call. If the final cost exceeds what

is initially agreed upon, those services will be provide pro-bono. If the final amount is determined to be less that estimated, the total cost will be re-established and if necessary, funds will be refunded.

Diagnostic Assessments are one appointment and payment is required at the onset of that meeting.

Once a client agrees to participate in testing (traditional psychological evaluation or Therapeutic Assessment), the total cost will typically billed in quarterly amounts, unless we discuss otherwise. Should you decide to stop an evaluation once it has been initiated, you will be billed for the services that have been completed. This may result in an incomplete evaluation with no formal diagnoses or recommendations provided.

For Therapeutic Assessments specifically, I expect we will have an initial meeting to establish questions for testing. For adult clients, we will then typically have 4-5 testing sessions, followed by 1-2 discussion sessions. For adolescents, after the initial meeting there will typically be 5-6 testing sessions, followed by 1-2 discussion sessions. Most appointments are 90 to 120 minutes. I will send a final letter and the Super Bill to you approximately 3-5 weeks after our last meeting. I invite you to have a follow-up meeting with me after you receive the letter to review it and our process. This session is provided pro-bono.

Billing Codes

The following schedule summarizes my fees for service as of September 2019. The number in brackets is the CPT code used by insurance company for billing. Psychotherapy clients would only be billed the 90791 and Psychotherapy Codes. Therapeutic Assessment clients will be billed using all three types of codes. If additional times is needed for any code, billing occurs in increments of $25 per 15 minutes.

Initial Diagnostic Assessment 90 minutes (90791) $250.00

Psychotherapy Visits and Codes:

- Individual Therapy 30 minutes (90832) $150.00
- Individual Therapy 45 minutes (90834) $175.00
- Individual Therapy 60 minutes (90837) $200.00
- Family Therapy with patient present (90847) $175.00
- Family Therapy without patient present (90846) $175.00

Psychological Evaluation Visits and Codes:

- Test Evaluation Services 30-minute increments (96130 & 96131) $100.00

  (Includes integration of data, interpreting standard test results and clinical data, clinical decision making, treatment planning and report and interactive feedback.)
- Test Administration and Scoring 60-minute increments (96136 & 96137) $200.00

Late Cancel or Missed Appointments (within 24 hours of appointment) $150.00

Payment

While payment may be made at the beginning of a session with cash or check, all clients must have a credit card on file. I utilize Ivy Pay (https://www.talktoivy.com/ivypay), which is a credit card payment system designed specifically for mental health providers.

Ivy Pay works with your debit card, credit card, HSA or FSA account. It is HIPAA secure, meaning it keeps our relationship confidential. When we first meet, I will send you an invitation text with a charge for either $1 or your initial full session fee depending on whether you plan to pay for that session by check, cash or credit card. You will receive a text from Ivy Pay that asks you to enter a credit card. Following the initial session and all subsequent sessions, your card will be charged through Ivy Pay. For psychotherapy clients, this means a charge after each session. For testing clients, you will typically be charged quarterly through the evaluation process.

I understand my financial responsibility and agree to have a credit card on file and pay my portion as described above. __________ (initial here)

I confirm that I have checked with my insurance company to understand what, if any, out of network benefits I may have. __________ (initial here)

I understand that there is a fee for missed appointments/late cancellations (within 24 hours of appointment); I agree to pay $150.00 for any missed appointments or late cancellations. This is uncollectible by insurance and will be my responsibility to pay. __________ (initial here)

I have read, understand, and agree to the above Financial Agreement and will make every attempt to keep my account with Raja M. David, PsyD, LP, LLC up-to-date, accurate, and in good standing.

____

Signature Date

____

Printed Name

<u>Assessment Clients Only</u>

Following an initial discussion, the quoted price for my Diagnostic Assessment or Therapeutic Assessment or Psychological Evaluation is __________. By signing below, I agree to pay this amount in full in quarterly increments, unless I am completing a Diagnostic Assessment in which case I agree to pay the full amount on the date of service.

____

Signature Date

____

Printed Name