# Psychological Support Services, PLLC at The Family Enrichment Center

## Specializing in Developmental Disabilities 236 LePhillip Court, Suite D Concord, NC 28025

704/786-4503  
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**Financial Policy/Cancellation Policy**

Because I value my relationship with you and believe that the best relationships are based on understanding, I offer these clarifications on payment and cancellations.

* Fees:   
  $150 for a one-hour Intake (initial appointment – all services, including Testing)  
  $115 per therapy hour (approximately 50 minutes) for Individual and Family Therapy   
  $45 per therapy hour for Group Therapy   
     
  Testing Fees

$125 per hour for testing. (Testing usually takes 3-4 hours, depending on a variety of factors, such as type of   
 assessment and complexity of the situation. There is an additional hour of billing for each hour of testing that  
 covers test scoring, report writing, editing of reports, as well as cost of tests and test materials)

$115 for a one-hour parent feedback of psychological test results

***Note:*** *A typical evaluation (from Intake through feedback) costs approximately $1000-$1300*

* Payment:   
  Payment (including deductible, co-pays and co-insurance), is due at the time services are rendered. In order to respect the clinical time we have available to us, you will not be required to take time to submit payment during your session. You are asked instead to designate on the attached form (Electronic Payment Authorization) the payment type that will be used to process payment. Payment will be processed by my office, and a receipt emailed (or texted) to you for each transaction.   
    
  Cash & Personal Checks will be accepted as well, but are preferred on an as needed basis. There will be a fee of $25 placed on your account for any returned checks.
* Cancellation Policy: Because your appointment time is a service hour reserved specifically for you, there are fees associated with No-Shows or Cancellations with less than 24 hours notice. These fees are assessed as follows:

$25 First No-Show or Cancellation < 24 hours  
 $50 Second No-Show or Cancellation < 24 hours

$90 Third and all subsequent No-Shows or Cancellations < 24 hours  
  
 *Please note that repeated cancellations may result in either forfeiture of permanent appointment “slot” or   
 termination of services.*

* Insurance: Please note the following:

1. I must emphasize that as a mental health care provider, my relationship is with you, not your insurance company. I am client focused rather than driven by managed care or insurance panels. Your insurance is a contract between you, your employer, and the insurance company.
2. Although I can submit the insurance claim for you, it is your responsibility to ensure that I am paid for my services. Please be aware that some, and perhaps all, of the services provided may **not** be covered under your benefit plan. For example, many insurance companies will not pay for psychological testing if no diagnosis is found or if the diagnosis is an Autism Spectrum Disorder, ADHD, and/or an Adjustment Disorder. If your insurance requires pre-authorization, it is your responsibility to follow-up with insurance and myself. Most insurance companies do not backdate authorization. **MY FEE REMAINS THE SAME REGARDLESS OF WHETHER OR NOT INSURANCE REIMBURSES YOU.**
3. Benefits are not determined by my office. Insurance benefits are determined by the type of plan chosen by your employer and will vary from company to company. It also makes a difference whether I am in-network or out-of-network with your insurance company. Your particular policy may base your allowance on a fee schedule which may not coincide with current acceptable fees.
4. I am committed to providing the best treatment to my clients. My fees are what are considered usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates. The percentage of the fees you receive from your insurance company is determined by how much you or your employer has paid for coverage.

* Past Due Accounts: If payments are not made within sixty (60) days, I will take the necessary steps to collect this debt through a collection agency. The cost of the agency (35%) will be added to the cost of your bill. As well, it is customary for an additional 1% to be added, as that is interest the money would earn if it were in the bank.
* Release of Information: By my signature below, I acknowledge primary responsibility for the payment of services to Angie Owen-Killar, MA or Psychological Support Services, PLLC. I request that my claims be filed to my insurance carrier. I also permit release of psychological information to the insurance carrier, or case manager, when the information is requested to process claims. I do not object to this information being released by mail, fax, or phone.

I have read the Financial Policy/Cancellation Policy. I understand and agree to the Policy.

X

Signature of Client/Responsible Party Date