MARNI BENDER, PH.D., LICENSED CLINICAL PSYCHOLOGIST

GENERAL BUSINESS POLICIES

CANCELLATIONS

If you need to cancel or reschedule an appointment, please provide 24 hours advance notice to avoid being charged the full fee for that reserved hour. You may text, call, or email to notify me of a need to or reschedule. Missed appointments without any notification are charged at the full rate even if you reschedule for that same week. If you let me know in advance and I have availability to reschedule you in the same calendar week, I will do so for no charge. Please note that insurance companies do not provide reimbursement for canceled or missed sessions. If we agree on a “standing” weekly appointment or other regular day/time (i.e., we meet at the same time each week/every 2 weeks), I reserve that time for you in my calendar as a “recurring” event, and do not offer that time to anyone else. If we miss a session for any reason, I will assume you will be at our next regular appointment unless we explicitly communicate otherwise.

FEES

My fee for the initial intake/assessment appointment is $180, and it is $165 for each subsequent 45-50 minute psychotherapy session. If I write letters or have any correspondence with any agencies or individuals (e.g., professors, insurance companies) on your behalf, you will be billed for my time in preparing any documents requested. If a telephone consultation is requested, I will bill for any amount of time over 10 minutes, on a prorated basis. If we arrange to have a full therapy session over the telephone or via video conferencing, you will be charged the same rate as for an in-person session. Legal proceedings (including full amount of time served for court testimony, depositions, hearings, preparation, wait time, and travel time) are billed at a rate of $300 per hour, payable in advance. All court related fees are regardless of location and regardless of the party who summons my participation.

PAYMENTS

Payment is due at the time of service unless we have agreed on a specific alternative arrangement (e.g., a 3rd party is paying for your treatment on a monthly basis). You may use cash, check, Mastercard, VISA, or Discover Card. A $5 charge will be included for any credit card payments less than $165. Returned checks will incur a fee of $15 plus bank charges.

My policy is to maintain a credit card on file. This allows me to settle your account quickly and easily should you find yourself without your usual form of payment so that you do not end up with an outstanding balance on your account. By providing your credit card information here you are giving me permission to run the card you choose automatically if services have been rendered and not paid for or if you do not provide at least 24-hour notice of a cancellation.

Card number: ______________________________ Expiration date: _________ 3 digit security code: _____ Billing zip code: ________

Signature matching name on card: ___________________________________

INSURANCE

At the end of each session, upon your request, I will provide you with a superbill which you may submit to your insurance company to take advantage of any out-of-network benefits you may have. If you decide to file a claim with your insurance company for reimbursement, I will work with you to make sure that they have all the information needed to process the claim.

If you are using an Aetna (non-EAP) Insurance plan, I will submit your claims for you. However, you must notify me in advance and must provide me with accurate insurance information. Claims will not be submitted retroactively and will be payable at my full rate. If your claims are denied for any reason (e.g., policy cancelled, service not covered), you will be responsible for paying for the full amount of the claim.

By signing this form, you are providing consent to release all information necessary to process your insurance claims, as requested by your insurance company (further explanation of this is included in the consent form you signed as well as in the GA Notice Form located on my website).

CONSENT

I agree to the billing practices noted above. I also understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event that I default on payment of my bill, I agree to pay all costs of collection. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I understand that this may include information from my chart (i.e. services rendered and balances due). I further agree that a photocopy of this agreement shall be as valid as the original.

Client signature: ____ Date: __________________

Responsible party signature (if different from patient): ______________________________________