



CENTER FOR PSYCHOLOGICAL HEALTH

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 cancel 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 \$225, and it is \$210 for each subsequent 50 minute psychotherapy session. Payment is due at your appointment.

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 \$400 per hour, payable in advance. All court related fees are regardless of location and regardless of the party who summons my participation.

My policy is to maintain a credit card on file. This allows me to settle your account quickly and easily should you 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

I am not in-network with any insurance company. However, 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 have. If you decide to file a claim with your insurance company for reimbursement, I will work with you to help you with the claim.

CONSENT

I, _____, agree to the billing practices noted above. I also understand that I am financially responsible for all charges regardless of whether they are covered by insurance or not. If I default on payment, I agree to pay all costs of collection. 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): _____