

DZ Counseling & Neurofeedback Training Services

Child, Adolescent, Adult, Couples & Family Counseling

501 Iron Bridge Road, Suite 15, Freehold, NJ 07728

Phone: 732-866-8611 ♦ Fax: 732-303-1221 ♦ www.dz-counseling.com

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SERVICES & BILLING- FEES & POLICIES

CPT Codes for regular services provided:

- 90791- Psychological Evaluation - \$185 45 minutes; \$245 1 hour
- 90834-Psychotherapy 45 minutes - \$185
- 90834-Psychotherapy w/Neurofeedback (brain-training) 45 minutes - \$225
- 90846 & 90847-Family/Couples Counseling- 45 minutes \$185
- 99366 - School Observations with CST = \$370* - 90 minutes *fee may vary depending on specifics of observation

These are not billable services/fess to insurance

- Travel Expenses – 15 minutes \$61
- Neurofeedback Monthly Rental - \$900 (paid at the time of pickup)
- Non-clinical Neurofeedback Session \$65
- Phone calls longer than 10 minutes will result in a fee to the client account: 10-20 minutes \$30; 21-30 minutes \$60. (These are not billable services/fess to insurance.)
- Requests for letters, reports, school visits, consults with school staff will result in a fee to the client -\$75 for any form of documentation up to 2 pages and \$50 per additional page.

***Less than 24-hour cancellation charge - \$140**

***No show/missed appointment charge - \$140**

***Return Payment Fee - \$35**

****Full payment is due at the time of session by cash, personal check, or credit card. A credit card is required to be placed on file within our secure client portal.**

Insurance: We are an out of network, non-participating of all insurance, private practice. As a courtesy to our clients to assist in getting reimbursement from your insurance in a timely manner, we will submit to your insurance electronically for you. We electronically submit weekly with an indication to insurance to send all correspondence/payment to the primary insured (known as non-assignment). Response time is typically 14-21 days. **Completion of the office portal and forms is required and a clear copy of the front and back of your insurance card will be needed as well. Please upload to the portal or email to Jen@dz-counseling.com. *Please note this courtesy service is not a guarantee of coverage/reimbursement for services and we do not verify coverage. It is highly recommended you contact your insurance directly to determine applicable reimbursement of coverage for out of network mental health benefits of the listed services.**

** This electronic service is not provided for Medicaid or Medicare primary, as our system does not support these insurances at this time. We are not a Medicare or Medicaid provider. It is recommended you contact your insurance to inquire about non-participating provider Medicare coverage/reimbursement. We will provide you with a superbill to submit with a Medicare claim form for you to receive any applicable reimbursement. If you have a supplement to Medicare, this superbill can be used as well for you to submit to them following their guidelines for submission. Medicaid clients will be provided with a monthly superbill to personally submit for reimbursement with required documents you will need to obtain from Medicaid.

Completion of all requested information within our secure client portal is required. I am aware that I am ultimately responsible for payment for services rendered by a clinician at DZ Counseling & Neurofeedback Training Services.

We reserve the right to raise our fees once a year. We will let you know well in advance of any increase.

Please contact Jennifer, Office & Billing Manager, if you have any questions and/or concerns at

Jen@dz-counseling.com

Please complete/print/sign clearly:

By signing here, I understand the office fees, policy of payment and insurance. If client is 14 or older: Parent/Guardian acknowledge & agree to office policy of payment and insurance.

Client's Name (14 yrs. and older) Date Client's Signature

If client is under the age of 18, Parent must sign:

Parent's/Legal Guardian's Name Date Parent's/Legal Guardian's Signature

PLEASE PRINT CLEARLY:

Insurance Information

Primary Insured's Employer Name: _____

Primary Insured's Full Name: _____

Primary Insured's Date of Birth: _____ **Primary Insured's Phone #:**

Primary Insured's Full Address: _____

City: _____ **State:** _____ **Zip Code:** _____

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY PHONE#: _____

INSURANCE I.D. NUMBER: _____

GROUP NUMBER: _____ **Relationship to Patient:** _____

****You will be asked the following information when activating and completing your portal. This information is encrypted in our system; therefore, we do require the below information to be completed. In the event our system is down and/or we will use the information below. A credit card is required to be on file. We do accept FSA/HSA cards, however if you are using an FSA/HSA card, we do require a credit card-Visa, Mastercard, Discover, AmEx- to be on file as a secondary payment to the FSA/HSA card.**

TYPE OF CARD IS TO BE LISTED: VISA, MASTERCARD (MC), DISCOVER, AMEX, FSA, HSA.

NAME ON CREDIT CARD: _____ **Billing Zip code:** _____ **CVC#:** _____

CREDIT CARD #: _____ **EXPIRATION DATE:** _____ **TYPE:** _____

NAME ON CREDIT CARD: _____ **Billing Zip Code:** _____ **CVC#:** _____

CREDIT CARD # _____ **EXPIRATION DATE:** _____ **TYPE:** _____

***Please remember to email a copy of the front and back of your insurance card to jen@dz-counseling.com or upload to the secure client portal.**