JOHN R DAY & ASSSOCIATES, LTD
CHRISTIAN PSYCHOLOGICAL ASSOCIATES

TESTING SERVICE FEE DISCLOSURE STATEMENT

Name of Patient: _____ Name of Responsible Party: _____

Christian Psychological Associates is committed to providing high-quality, comprehensive psychological assessment services. Due to the time and administrative resources required for testing, we have implemented a **Testing Service Fee** to help support these services.

What is the Testing Service Fee?
The **Testing Service Fee** is a one-time administrative fee that helps cover the non-billable aspects of the testing process, including:

- Scheduling and reserving extended clinician time
- Preparation and coordination of testing materials
- Communication with referring providers
- Coordination and communication with clients, caregivers, and other raters
- Administrative support throughout the entire process

Fee Structure
The fee structure reflects the complexity of an evaluation:

- Standard Evaluation: $100-$200
- Complex or Specialized Evaluation: $300-$400
  (Your clinician and/or the Testing Coordinator will inform you of the applicable fee.)

The Testing Service Fee is due prior to the scheduling of testing. Payment may be made by credit card, check, or other accepted methods through our front office or billing department.

Insurance

- This fee is **not reimbursable by insurance**.
- Insurance may cover the clinical testing and report writing (see CPT codes on Testing Estimate), which we will bill as appropriate and allowable.
- This fee is strictly for administrative and support services not covered by insurance providers.

Refund Policy
This fee is **non-refundable** once testing has been scheduled and preparatory work has begun. In the event of cancellation prior to test preparation, partial refunds may be considered on a case-by-case basis. *Please consider carefully before beginning testing.*

HIPAA NOTICE: *All information shared during the psychological testing process, including the psychological report, is protected under the Health Insurance Portability and Accountability Act (HIPAA). Your records will be handled in accordance with federal and state confidentiality laws.*

Acknowledgment & Consent
I acknowledge that I have received and reviewed this Testing Service Fee Disclosure Form.

Client/Guardian Signature: _____ Printed Name: _____ Date: _____