Pediatric Psychological Services

100 HIGH STREET, SUITE 200 WESTWOOD, MA 02090
PHONE/FAX: (781) 898-0127
WWW.PEDIATRICPSYCHOLOGICALSERVICES.COM
AKOVACS@PEDIATRICPSYCHOLOGICALSERVICES.COM

PATIENT RESPONSBILITY AGREEMENT

Dear Patient,

Welcome to Pediatric Psychological Services. I appreciate the opportunity of being of service to you and your child. My office is dedicated to excellence in patient care. To maintain high standards, I believe that it is important that to communicate my policies to you. Please take a moment to read and become familiar with these policies. Should you have any questions, I would be happy to help. By presenting these policies in advance, we can avoid any surprises or misunderstandings. I appreciate your time and your understanding.

PATIENT RESPONSBILITIES

☐ **Payment Responsibility:** I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or my family members. I understand that
payment or co-payment is due at the time services are rendered unless special arrangements have been made.

☐ **Phone Consultations:** In order to be flexible and responsive Dr. Kovacs is available to speak with the clients by phone when necessary. I understand, however, that all calls exceeding ten minutes will be billed in a pro-rated fashion on the basis of my session fee, which is $175/hr. Further, insurance will not usually cover the cost of a phone session; therefore, this fee is an out of pocket expense.

☐ **Charges for Additional Services:** I understand that charges will be added to my account for other professional services rendered. This charge will be in increments of 15 minutes and Pediatric Psychological Services will always discuss additional charges with me. Other professional services include consulting with other professionals with my permission, preparation of records or treatment summaries, and the time spent performing any other service I may request.

☐ **Appointments & Cancellations:** I understand that, I am required to provide at least 24 hours advance notice if unable to keep the scheduled appointment because the scheduled time slot has been reserved exclusively for me and/or my child. In the event
that I do not provide 24 hours advance notice, I am financially responsible for the reserved appointment. There is a $500 no-show fee for neuropsychological evaluations that are not cancelled within 24 hours. Pediatric Psychological Services may make exceptions and waive the fee, at its discretion, for emergency or unusual circumstances. I

understand that insurance companies do not provide reimbursement for cancelled sessions. Repeated missed appointments may result in termination of therapy. There may be a time when my therapist may need to cancel my appointment for an emergency; Pediatric Psychological Services will make every effort to reschedule me and / my child in an appropriate time frame.

☐ **Returned Check Fee:** I, the undersigned, agree to pay a fee of $25.00 for any check returned by my financial institution regardless of reason.

☐ **Delinquent Accounts:** I understand that payments not received within 90 days are subject may be turned over for collection and I will be responsible for all costs of collection monies owed, including court costs, collection and attorney fees.

I fully understand and agree to the above policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

_____	_____	_____
Parent or Guardian Signature	Print	Date