Michelle L. Hobby, Ph.D.
Licensed Psychologist, Ps018424
427 Main Street, Suite 2, Hellertown, PA 18055 ~ (855) 414-2523

Financial agreement

First, Middle, Last Name: _____
Date of Birth: _____

Insurance Information (please provide a copy of your insurance card- front/back)

Insurance ID number: _____
Primary Insurance Company (name, address, phone number), Payor ID:
_____
_____
_____

Group Number: _____
Name & Birth-date of primary insurance subscriber: _____
Employer name _____

Credit Card Authorization Form

• If you plan to use a credit/debit/HSA/FSA card, please note that the charge will appear as "Ivy" on your credit card statement in order to protect your privacy.

• In order to set-up your credit card payment account with me, I will enter your mobile number into Ivy Pay. They will then text you a link to set-up your secure, HIPAA-compliant payment account.

• If you have a credit card account, please note that LATE CANCELLATIONS/NO-SHOW FEES will automatically be billed to this account once it has been established that it was a non-emergency event. HSA/FSA cards cannot be billed for missed visits, so you would be responsible for paying those in either cash/check.

• Ivy will store your credit card information in their secure, HIPAA-compliant system, which will allow you to pay automatically at each visit without presenting your card.

By signing below, I agree to pay a fee of $_____ per individual session, and $_____ per family/couples session to Michelle Hobby, Ph.D., for psychological services provided. I understand that this fee is subject to change, and any change in fee will be as mutually agreed upon. I understand that my fee is subject to periodic review, particularly if I am paying a reduced fee and my financial situation changes. I agree to pay for services at the time they are provided.

Co-payment: (in-network insurance patients): $_____

Deductible remaining: $_____

If I am utilizing my health insurance to pay for these services, I hereby assign any payments from my health insurance provider to Michelle L Hobby, Ph.D. By signing below, I hereby authorize the release of any medical information needed by my insurance provider to process claims submitted for payment. My co-pay/co-insurance/deductible amounts are due at the time of service.

If for any reason my insurance company incorrectly processes or rejects my claims, it is my responsibility to call/contact the insurance company to have them reprocess the claims. I agree to be responsible for any charges not covered by my health insurance and to pay any remaining balance within 30 days of the session date. I understand that my health insurance cannot be billed for missed appointments, and I am responsible for the missed session fee.

I agree to pay the full fee for appointments canceled or missed **without providing 24hr notice prior to the scheduled appointment.*

Signature: _____ Date: _____