Mountainview Clinical Psychology, PLLC

Cancellation Policy & Patient Financial Responsibility

GUARANTEE OF PAYMENT AND ASSIGNMENT OF INSURANCE BENEFITS: For value received, the undersigned guarantor and/or patient (hereinafter the "Responsible Party") promises to pay to Mountainview Clinical Psychology, PLLC all charges incurred for services rendered to the Responsible Party. The Responsible Party understands that Mountainview Clinical Psychology, PLLC will process the paperwork to complete insurance claim(s) but only as a courtesy to the Responsible Party, and the Responsible Party authorizes Mountainview Clinical Psychology, PLLC to release any and all medical information necessary to complete insurance claim(s) and assigns any monies due and owing under the insurance contract to Mountainview Clinical Psychology, PLLC. It is, however, understood and agreed that the Responsible Party is responsible for all monies due and owing for services rendered by Mountainview Clinical Psychology, PLLC in the event insurance does not pay for these services. It is acknowledged that the ultimate completing and following-up of any insurance claims is the responsibility of the Responsible Party. The Responsible Party authorizes use of this form on all insurance claim submissions. Release of records to referral sources is also authorized. The Responsible Party agrees to be bound by the terms and conditions of this account with Mountainview Clinical Psychology, PLLC.

Your copay is expected at the time of service. We will file the Responsible Party's initial insurance claim(s) and provide documentation necessary for insurance reimbursement. We do not, however, guarantee that each service will be covered or what percentage will be covered. In the event that the Patient's/Responsible Party's insurance does not cover our services (or any portion thereof), Mountainview Clinical Psychology, PLLC will work with the Responsible Party regarding payment (e.g., setting up a payment plan).

Responding to Forensic/Medical Legal requests, conferences and telephone calls with attorneys involve additional time and record keeping. The Responsible Party is responsible for all direct costs and expenses associated with Mountainview Clinical Psychology, PLLC and its attorney responding to discovery requests (including depositions and subpoena duces tecum time and labor costs) and with conferences including, but not limited to court appearances, preparation of reports, photocopying, faxes, out of office travel, overnight delivery and courier services. These expenses are billed to the Responsible Party and to the Patient's/Responsible Party's Attorney. The Responsible party, however, remains responsible for payment of these charges if not paid in full within sixty (60) days.

Cancellation Policy:

Testing Appointments:

All testing appointments must be confirmed within 3 business days prior to the appointment. If we are unable to secure a confirmation from you within 3 business days of the appointment, your appointment will be cancelled and filled with another patient. **Be sure to respond to appointment reminder texts or phone calls to secure your appointment.** A minimum of 48 hours' notice is required for cancellation of confirmed testing appointments. These appointments are blocked off for large periods of time (3-4 hours), reserved only for the patient. If this notice is not received, the Responsible Party will be charged a no-show fee ($250 for neuropsychological evaluation) which was reserved for the appointment at the rates posted in the office of Mountainview Clinical Psychology, PLLC. Insurance will not be billed for missed/canceled appointments.

60-minute Intake/Feedback appointments:

A minimum of 24 hours' notice is required for cancellation of confirmed intakes/feedbacks. The no-show fee for confirmed intake/feedback appointments is $50.

If you have any questions, please speak with Dr. Husk/Dr. Mahan. Your signature indicates that you have read the above and agree to the terms contained therein. These agreements are irrevocable.

Responsible Party: _____ Signature: _____

Date: _____

Guardian Signature (if patient unable to sign**): _____