Child and Adolescent Health Specialists, PC
223 Chief Justice Cushing Highway
Suite 201
Cohasset, MA 02025
T. 781.383.8380
F. 781.383.8382
childhealthspecialists.com

Counseling Payment Agreement Name of Patient ___________________________

- Fee Structure-
  - $150 per one on one session (individual, parents only or family)
  - $30 per Telephone consultation/Collateral Contact/Case management (over 10 minutes) (not covered by insurance)
  - Payment is expected at time of appointment/service by cash, check or credit card
  - If an economic hardship develops, a reduced fee or other accommodations may be available. Please present 1040 tax form. Federal guidelines will be followed.
  - Other non- covered services are payable on date of service
- Insurances accepted to which we will submit claims: Blue Cross and Blue Shield, United Behavioral Health (for Harvard Pilgrim/ United Healthcare), Tufts. If you have out of network benefits, payment is due at the time of appointment and we will provide you with a receipt for you to submit to your insurance for reimbursement.
  - Client is responsible for co-payment at the time of the appointment.
  - By law, our Practice cannot waive or reduce insurance fees or co-payments.
- Late Cancellation/Broken appointment policy-
  - 48 hours' notice during business hours, (Friday for Monday appointments), is required to cancel or reschedule an appointment.
  - Late Cancellations/No show will be charged to your credit card below if less than 48 hours' notice is given.

  Type: (circle one) MasterCard or Visa. Name on Card: _____________________________________

  Credit Card #: _______________________________ Expiration Date: _______________ CVV # : _________

  Exceptions to this policy may be made in the instance of a documented serious medical emergency or serious immediate family emergency.
  - If late arrival, the appointment cannot be extended and the full fee applies.
- Balances due-
  - Outstanding balances must be paid prior to the next appointment.
  - Appointments cannot be scheduled if balances have not been addressed.

Agreement: I understand that I am responsible for payment in full of all charges.

I, _______________________________________, agree to the above described payment agreement, and

A) If billing to insurance: I request that payment of authorized insurance benefits be paid directly to Child and Adolescent Health Specialists, PC. I also authorize Child and Adolescent Health Specialists, PC to release all information necessary for the processing of insurance claims to HCFA, its agents or any other insurance company to determine the benefits payable for related services.

____ Date ________________

OR

B) If paying privately: I agree to pay the fee of $150 at the time of service.

____ Date ________________