Jefferson and Associates Psychological Services, P.C.
Client Service Agreement

Informed Consent for treatment:

- I, _____ for/and _____do voluntarily consent to care and treatment by Terry W. Jefferson, Ph.D., Suzanne R. Eaton, Psy.D., Bruce M. James, LPC, LMFT, Sarah R. Ball, LCSW, Patricia Sova, LPC, LMFT and/or Susan Eick, Psy.D..
- I understand that like other healing arts, psychology is not an exact science and that no guarantees are being made as to the result of evaluation or treatment.
- I am aware that I am an active participant in this endeavor and I share the responsibility for the treatment process, including goal setting and termination.

Confidentiality:

- I understand that our work will be kept confidential, with the exception, of legal limitations on confidentiality.
- The therapist is bound by professional standards and law to take appropriate action on behalf of any client who presents a danger to self or others.
- Certain major violations of the law (such as abuse or neglect) must be reported to the appropriate authorities.
- The therapist must respond to any court subpoenas ordering the therapist to give information to the court regarding and client.

Emergencies:

- After normal office hour therapist can be contacted by calling the office to get their emergency contact number.

Financial:

- It is your responsibility to be aware of your specific insurance policy deductibles, co-payments, and co-insurance. It is your obligation to remit all appropriate payments. Any estimate the office makes will be our best faith effort to determine coverage and does not guarantee payment from your insurance. <u>The amount for which you are responsible (any deductibles, co-payments, co-insurance, or non-covered services) will be required, at the time of service.</u>
- If this practice is not contracted with your specific insurance plan, even if you have out-of-network benefits, all charges will be due, at the time of service.
- Your insurance policy is a contract solely between you and your insurance company. If you fail to notify us of an insurance change, you will be fully responsible for any amount not paid by your insurance company.
- For service rendered to minor patients, the accompanying parent or guardian will be responsible for payment.
- 24-hour notice of cancellation is required to avoid being charged a late cancellation fee.
- <u>There will be a $50.00 charge for any failed therapy appointment or late cancellation; $150 charge for any failed or late cancellation of testing appointment.</u>
- Two failed appointments may result in referral to another therapist.
- Educational testing and court ordered testing is not a covered service by insurance, and reimbursement is fully the responsibility of the client.
- Written testing reports will be provided after the account is paid in full.
- The fee for any check returned for non-payment is $50.00
- I agree to pay all collection/court fees and interest incurred for any unpaid balance after 30 days.
- Fees for court appearances are based on the guidelines set by the Lynchburg Academy of Medicine and the Lynchburg Bar Association and are to be paid in full in advance.
- I understand that I am responsible for charges incurred by persons/agencies who are consulted as part of my treatment.

Insurance Authorization and Assignment:
I hereby authorize Jefferson and Associates Psychological Services, P.C. to furnish information to insurance carriers and referring physicians concerning my illness and treatment and I hereby assign to the provider all payments for professional services rendered to myself or my dependents.

I have had the opportunity to read and have any questions answered regarding the financial and cancellation policies of Jefferson and Associates Psychological Services, P.C. and understand that by signing this form I will be held financially responsible for this account.

_____ _____
Signature of client (or legal guardian) Signature of client (or legal guardian)

_____ _____
Date Date