Financial Agreement

THE INTEGRAL PSYCHOLOGY CENTER, INC.

Client Responsibility

The client (or person responsible for the client) is ultimately responsible for the payment of all services received at The Integral Psychology Center, Inc. If IPC bills a medical insurance company for services, this is done as a courtesy to the client and is not a substitute for the client's responsibility for payment of services.

Payment Options

___ Insurance Coverage IPC can bill certain insurance companies for services. You are responsible for any deductibles or copayments at the time of each session. You are ultimately responsible for payment of any services received not payed for by your insurance company. Please notify us immediately if you have a change of insurance carrier or coverage, because that can change the amount for which you are responsible.

If you choose to pay for services yourself, you may (Please initial your preference)
___ Pay cash or check at each appointment
___ Charge your VISA/Mastercard account
___ Authorize automatic bank deductions from your checking or savings account
___ Make individual arrangements for monthly payments with your therapist

As most insurance policies have a limit of payment, you may want to consider secondary payment options should you continue therapy beyond the limit of your insurance.

Payment Procedure

Any balance over 30 days old becomes the client's responsibility to pay, and payment is expected to be made within 30 days after the account becomes 60 days old. If the insurance company has not paid within 30 days, you will be billed for that amount. If the insurance company subsequently pays, you will be reimbursed.Delinquent accounts may be turned over to collection agencies or credit bureaus, and information which is necessary for that purpose may be disclosed.

Appointment Cancellation

Appointments which are canceled with less than 24 hours notice and/or no-show appointments will be billed to the client for the full amount. Insurance companies do not pay for no-show charges or late cancellation charges or for telephone consultations.

Fee (to be filled in at the office)

Your fee will be $_____ per 55 minute session; or $_____ per 45 minute session.

Initial Assessment/Intake session will be billed at $_____.

Other Conditions

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_____

I have read the above financial agreement, I understand the above, and agree to the above.
Signature of client and/or responsible person _____

Date _____