

Jonina D. Bolton, Ph.D.
Licensed Psychologist

REVISED FINANCIAL AGREEMENT

Patient Name(s): _____ **Date of Birth:** _____

This revised financial agreement replaces and nullifies any pre-existing written financial agreement with Dr. Bolton. The patient, or responsible/accountable party (if the patient is a minor), is responsible for paying the fee at the time that services are rendered. If you plan to utilize insurance benefits, then please notify Dr. Bolton of your intention to do so, in advance. Dr. Bolton will submit insurance claims on your behalf to companies for which she is an in-network provider only. However, in the event that the claim(s) are denied by your insurance company, you will be held financially responsible for paying the fees in-full and for seeking reimbursement from your insurance company.

If the patient or responsible party has scheduled an appointment and chooses for any reason not to use that appointment time, then twenty-four (24) hour notice is required. If inadequate notice is given, or if a patient does not show for an appointment that he/she has reserved, then the patient or responsible party will be held financially responsible for paying the fee. The fee for the first two missed or cancelled appointments without 24-hour notice is **\$50.00**, with all subsequent missed or cancelled appointments being charged the full fee of **\$165.00** for the appointment. Insurance companies do not pay any portion of the fee for a missed or cancelled appointment and the reduced rate will not apply. *I understand my financial responsibility for reserved appointments, including my responsibility to notify Dr. Bolton with at least 24-hour notice to avoid being charged a fee.* **Please initial here.** _____

Fees are subject to annual increases. There is a charge of \$20.00 for all checks returned for insufficient funds. If your payment by check is returned on two occasions, then all subsequent payments must be made by other means.

The patient or responsible party is required to guarantee payment for services used. In the event that any collection procedures become necessary, the patient is responsible for all fees for services rendered, interest accrued, document preparation time, photocopying fees, and all costs of collection, including attorney fees and court fees.

Having been notified of these terms, I/we agree to the following fee arrangements:

Insurance pay: Deductible _____
Co-pay of \$ _____ per therapy session (initial here) _____
Co-insurance of % _____ per therapy session (initial here) _____
Private pay fee of \$ _____ per therapy session (initial here) _____
Private pay fee of \$ _____ per hour of testing (initial here) _____
Private pay fee of \$ _____ other _____ (initial here) _____

Patient Signature(s): _____ **Date:** _____

_____ **Date:** _____

Jonina D. Bolton, Ph.D.: _____ **Date:** _____

For Insurance Pay Only:

Name of Primary Policy Holder: _____ **Date of Birth:** _____

Name of Primary Insurance Company: _____ **Member ID#** _____

*Signature on File: I authorize the release of any clinical information necessary to process claims made on my behalf or that of my family member(s). Please accept a photocopy of this authorization as if it were an original. My signature below acts as the signature on file.

Signature: _____ **Date:** _____

*Assignment of Benefits: I hereby authorize and direct payment of insurance benefits to Jonina D. Bolton, Ph.D. for professional services rendered. I understand that I am financially responsible for all charges not covered by this assignment.

Signature: _____ **Date:** _____
