**Churchland Psychological Center**

**3101 American Legion Rd, Suite 21B**

**Chesapeake, VA 23321**

**1709 Colley Avenue, Suite 310 6477 College Park Sq., Suite 216**

**Norfolk, VA 23517 Virginia Beach, VA 23464**

**(Phone) 757-483-3404 (Fax) 757-483-0461**

**Patient Responsibility:**

* To furnish a current insurance card and to provide the following information to your therapist: whether you have to be pre-authorized for treatment, if you have an annual deductible, the total number of sessions per year your insurer will reimburse, and your co-pay per session.
* To confirm all financial arrangements and to discuss all payment and billing questions directly with your therapist.
* To be held directly responsible for any co-pay amount, as well as any insurance payment that Churchland Psychological Center (CPC) has not received from your insurer within 60 days.
* To make your payment at the beginning of each session directly to your therapist. Credit card payments are to be made at the front desk, before each session. Checks and cash are paid directly to the therapist.

**Churchland Psychological Center Responsibility:**

* Churchland Psychological Center (CPC) will file your insurance at your request.
* CPC will not be held responsible for any administrative error(s) in processing claims, or for denial of claims by your insurer, and shall not be used as an offset against your bill.

**Missed Appointments:**

* Missed appointments are not reimbursed by any insurance company. Because your therapy appointment is reserved for you, y**ou are required to give 24-hour notice for cancellations or you will be charged $50.00 for the missed appointment.** Cancellations must be left on your therapist’s voice mail, noting the reason for your cancellation. During normal business hours, cancellations may be called into our business office directly (483-3404), but please note that we will direct your call to your therapist.

**Collections:**

* We will make every effort to work with you if there are financial problems. However, if your account should be sent to collections, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorneys’ fees, we incur in such collection efforts. In addition, interest charges of 18% per annum from date of services rendered on unpaid balances will be charged.
* You agree to pay $30.00 for any returned checks that you write to CPC.

**Electronic Communications:** Please note that communications through voice mail, cell phone, email, and texting are not considered a “protected environment.” Therefore if you choose to communicate electronically you signature on this form indicates your understanding of this issue.

**Your Signature On This Contract:**

* Indicates your agreement with the terms of this contract with CPC.
* Indicates your agreement that CPC may file insurance claims on your behalf, receive insurance reimbursements, and release information requested by your insurance company.
* Indicates your understanding that electronic communications are not considered a “protected environment.”

# Your Privacy:

* This office is in compliance with all state and federal laws regarding your privacy. Our privacy statement is posted in the waiting room. You may ask the office staff or your therapist for your own personal copy. Your signature serves as acknowledgement of this policy.

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Signature of Patient/Parent/Guardian Date

Responsible for Payment

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Print Name