POLICY STATEMENT
CHILD PSYCHIATRY ASSOCIATES, PC

1. Fees for services vary according to your specific insurance plan. Ask your therapist if you have any questions about your fee schedule.
2. **CO-PAYMENTS MUST BE MADE AT THE TIME OF SERVICE.** If you need a payment plan, please tell us immediately so our billing department can help you make alternate arrangements. If you share co-payments for your child's care because of a divorce, you must pay at the time of service and arrange for coordination of reimbursement on your own.
3. We will file your insurance for you if you have provided us with the necessary information. Please notify us immediately if you change insurance carriers.
4. If you need to cancel an appointment, you ***must*** give a 24 hour notice to avoid a charge to your account. If you request an emergency cancellation, please discuss this with your treatment provider. PLEASE INITIAL HERE ____________.
5. It is the parent's responsibility to make certain that both biological parents are aware of treatment given through this office.

PSYCHOLOGICAL REPORTS/WRITTEN CORRESPONDENCE

1. If you or your child is undergoing a psychological evaluation, there is an extra charge for the written report to cover the time involved in scoring the results and preparing an interpretive report. A fee of $35.00 will be charged to your account.
2. If you request your therapist or physician to send other correspondence on your behalf, there will be a fee of $25.00 charged.
3. You may be required to make payment before the report/letter is sent.

PHOTOCOPYING Fees must be paid before records are released.
To have records copied, a photocopying fee will be assessed as follows:
$10.00 fee for 1-20 pages; $20.00 fee for 21-50 pages; $40.00 for more than 50 pages.

IT IS VERY IMPORTANT THAT WE HAVE YOUR CURRENT ADDRESS AND TELEPHONE NUMBER. PLEASE NOTIFY US IMMEDIATELY WITH ANY CHANGES.

I understand that some services through Child Psychiatry Associates, PC may not be covered or paid in full by my insurance or third party payer. If my insurance or other third party payer denies payment or does not pay in full, I agree to be personally and fully responsible for payment.

Please sign to indicate you understand the information on this policy statement.

______________________________ ______________
SIGNATURE DATE

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PRINT PATIENT'S NAME

(over)