

*Poehailos, Dupont & Associates, PLLC*

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Contract for Psychiatric Evaluation

Patient: \_\_\_\_\_

Financially responsible party: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_ I am agreeing to psychiatric assessment for me/my child with Poehailos, Dupont, & Associates, PLC.

\_\_\_\_\_ I understand that my insurance company may cover some but not all of the evaluations administered as part of this assessment and that I am financially responsible for all remaining charges.

\_\_\_\_\_ I understand that there may be additional fees related to coordination of care, consultation (including phone calls and meetings), record review, and educational planning/providing resources, that are not covered by my insurance and will be priced at the hourly fee of \$250/hour. I understand I will be billed as these services are rendered.

\_\_\_\_\_ The Pre-Intake Administration fee for this assessment is \$200. I understand that this fee is due at time of evaluation. This fee is determined by the level of assessed complexity, referral questions, and variety of assessment measures administered.

\_\_\_\_\_ I understand that there may be co-payments, co-insurance, and deductible costs based on my insurance plan that are direct charges to me.

\_\_\_\_\_ I understand that the initial intake session and any follow up interviews or feedback related appointments will be billed as therapy appointments and charged to me based on my mental health insurance coverage.

\_\_\_\_\_ I understand that should I call to cancel an assessment appointment with less than 24 hours notice, or no-show for an appointment, I will be charged in full for the session. Assessment is billed by the hour and the fee is \$250 per hour. A missed appointment is not billable to insurance and my credit card on file will be processed for the full amount.

By signing below, I acknowledge that I have read and understood the previous statements and agree to move forward with the assessment process.

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Signature

Date