FINANCIAL AGREEMENT

Dr. Picciocchi's Initial Diagnostic Interview	$175.00
Dr. Picciocchi's 45-50 minute psychiatric session	$125.00
Dr. Picciocchi's subsequent 20-25 psychiatric session	$80.00
Dr. Picciocchi's subsequent 75-80 minute individual psychotherapy session	$180.00

PLEASE NOTE:
There are additional charges if sessions continue beyond the scheduled time or if phone calls extend beyond 5-10 minutes ,and for school meetings/ observations. **INSURANCE DOES NOT COVER THESE COSTS.**

PLAN A- Cash payments of fees

1.) If I file my own insurance or do not have insurance that covers psychotherapy, I will pay the full fee to Dr. Picciocchi on the day that services are rendered.

2.) **I AGREE TO PAY THE FULL FEE FOR MISSED APPOINTMENTS AND ALL APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE.** Payments must be made before or at the time of the next appointment.

3.) If I do not honor this financial agreement and develop an outstanding balance, I will pay the charges within 30 days. I agree to an interest charge of 1.5% per month (18% per year) if my balance is not paid within 30 days. If payment is not made, I waive the right to confidential ty for purpose of collection of the said fee. Any reasonable attorney fees and costs incurred by Dr. Picciocchi for the collection of the past due account shall be my obligation as well.

PLAN B- Cash plus insurance payment of fees

I authorize the release of any medical records or other information necessary to process this claim. I also authorize any payment of medical benefits to the above referenced provider for services rendered. However, it must be fully understood that the contract is between me and my insurance company and I am fully responsible for any amount not paid by my insurance.

1.) **I will submit to the office my co payment on THE DAY OF MY SESSION**. Dr. Picciocchi will file my insurance and any insurance payments received are to be deducted from the balance of my account.

2.) The office does not guarantee that my insurance company will pay. They will make every attempt at the beginning of my health care to receive verification of my policy and what it covers. However, if for some reason, my insurance claim is denied, or payments are requested to be refunded, I am responsible for the full amount of my bill.

3.) The office will not enter into a dispute with my insurance company regarding my claim. This is my responsibility and obligation.

4.) I will pay the percentage of my responsibility as I continue (e.g. if my insurance pays 80% of my care, I will pay 20% of each office visit).

5.) **I AGREE TO PAY THE FULL FEE FOR ALL MISSED APPOINTMENTS AND ALL APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE**. Payments must be paid before or at the time of the next appointment.

6.) If I do not honor this financial agreement and develop an outstanding balance, I will pay all charges within 30 days. I agree to an interest charge of 1.5% per month (18% per year) if my balance is not paid within 30 days. If payment is not made, I waive my rights to confidentiality for purpose of the said collection fee. Any reasonable attorney fees and costs incurred by Dr. Picciocchi for the collection of the past due account shall be my obligation as well.

I understand and agree with all of the above office policies.

I will pay today by: Circle one. CASH CHECK CREDIT CARD

_____Plan A or B _____
Signature Date