Child & Adolescent Psychiatry Consulting LLC

DBA

Behrend Psychology Consultants / **Horses Treat**

3930 8th St. So. Ste.101,Wis.Rapids, WI 54494 | M407 Hwy 97, Marshfield, WI 54449

715-423-2030 ; Fax: 715-423-2032 | 715-318-0047 ; Fax: 888-485-4412

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Billing Policies

Psychiatrist Services:	$390-$420 Initial Evaluation
	$280-$320 45-50 minute Evaluation/Management Therapy
	$295-$305 20-30 minute Evaluation/Management Therapy
	$280-$320 Family Session
	$100-$130 Group Therapy
Psychologist Services:	$300-$325 Initial Evaluation
	$200-$225 45-50 minute session
Master Level Services:	$240-$265 Initial Evaluation
	$165-$190 45-50 minute session
Horse Fee	$60 Per session when utilized (NOT paid by insurance)
Telephone Consultation:	$40/increment of up to 10minutes at the discretion of the clinician
Clinicians Reports/Letters/Consultations	$200/hr in 15minute increments
Forensic/Court Related Work	$350/hr in 15minute increments
	$85 No Show Fee/Cancellations Less Than 24 Hours, Three no shows, or late cancellations, may result in discharge from the clinic

Please be advised that telephone consultations are not insurance billable and will be the patients' responsibility.

Prescription refill requests require a 7 day notice.

If you have health insurance, a claim will be filed with your insurance company at no charge provided we have your ***complete*** insurance information. This is done as a service to you, but this office cannot accept responsibility for collecting from your insurance or for negotiating a settlement on a disputed claim. You are responsible for your account.

Please contact your insurance company and/or employer to verify coverage of services provided at CAPC/BPC/HT prior to your first appointment. Although many insurance companies cover our services, we can make no guarantee that any particular company will provide payment. I understand I am responsible for any fees not paid for by insurance. Should the account be referred to an attorney or agency for collection, I will be responsible for all attorney fees and expenses.

All appointments are prescheduled, and you will be charged for missed or canceled appointments, unless you notify our office at least 24 hours in advance. You should be aware that insurance will not pay charges for missed appointments. Therefore it will be your responsibility for payment of the "No Show" charge.

CAPC/BPC/HT reserves the right to seek legal means to secure reimbursement. If necessary, this may include the release of essential information (names, dates of treatment, unpaid fees, etc.) to attorneys, the courts or collection agencies.

Co-Pay and deductible amounts are due at the time of service. After your insurance company has paid its maximum amount, payment on the balance is expected within 30 days of billing.

If specific fee and/or payment arrangements at variance with the above policy have been made, they must be detailed below:

_____

I have read the above policies and procedures regarding my financial responsibilities. I understand them, and I consent to them. I have been informed of the availability of a copy of this form upon request:

Signed:_____ Date:_____

Therapist:_____ Date:_____

Authorization to pay benefits: I hereby authorize payment directly to Child & Adolescent Psychiatry LLC from my insurance company for services performed at this clinic. I recognize and accept personal responsibility for the deductible amount and for any balance outstanding after payment of such insurance benefits. I authorize the release of any medical or other information necessary to process this claim.

Signature: _____Date:_____

(If under 18-parent or guardian signature required)