Christine A. Baser, R.N., Ph.D.
A Professional Psychology Corporation

Fee Schedule and Policies

My fee is $_____ per session. Sessions are _____ minutes in length. In addition to weekly appointments, it is my practice to charge this amount on a prorated basis for other professional services you may require of me, such as report writing, telephone conversations, or consultations with other professionals. In unusual circumstances, you may become involved in a litigation which may require my participation. You will be expected to pay for the professional time required even if I am compelled to testify by another party. I charge $_____ per hour for preparation and attendance at any legal proceeding.

It is the policy of this office to request payment at the time services are provided unless other arrangements are made in advance. We are available to assist in the billing of your insurance carrier and will accept assignment of benefits on your behalf. However, your insurance policy is a contract between you, your carrier, and possibly, your employer. The fees for services provided to the patient are part of a contract between you and this office. Therefore, you will be responsible for the fees, including those not paid for any reason by your insurance carrier.

You/your insurance company will be billed at $_____ per session.
Your insurance will pay $_____ per session.
Your cost-share will be $_____ per session.
Your deductible of $_____ has not/has been paid.

If you have insurance, final determination of your co-pay (cost share) will be established by the actual payment made by your insurance company. You will be responsible for the difference between what your insurance pays and the fees set by this office (or the maximum fee set by your insurance company). It is expected, but not guaranteed, that your insurance will pay $_____ per session, with a $_____ deductible. There will/will not (circle one) be a maximum payable amount of $_____ set by your insurance company/managed care company.

Cancellation: When an appointment is made, that time is reserved exclusively for you. A 24-hour notice is required for cancellation without charge. A charge of $_____ is made for late cancellations and missed appointments. Insurance carriers do not pay for missed appointments.

In signing this form, you are indicating your understanding and consent to all of the above. Additionally, you agree to hold harmless this office regarding any

claim made against unpaid fees. It is the policy of this office to send to a collection agency or file in small claims court for any unpaid fees.

This office reserves the right to institute an interest charge of one percent per month (or as allowed by law) for fees unpaid for an extended period, with timely notice given to you so that the problem may be corrected before interest charges are applied.

As with any issue which may present itself, you should feel free to discuss with us any questions that arise regarding fee policies. We understand that there are times when difficulty with finances may temporarily prevent you from meeting your obligation under this contract. Should such a circumstance present itself, please contact this office at once so that we may make appropriate arrangements.

Patient Name _____

Patient Signature _____ Date _____