



FAYETTEVILLE
PSYCHOTHERAPY
Associates, PLC

William E. Spaine, Psy. D.
Clinical Psychologist
225 North East Avenue, Fayetteville, AR 72701, (479) 442-8900

Patient Responsibility and Insurance Release

I understand that I have contracted for psychological services with Dr. William Spaine, Psy. D. for fees as follows:

Intake Interview	\$225.00
Psychotherapy, 50 minutes	\$150.00

I understand that I alone am responsible for paying these amounts for services rendered by Dr. Spaine on the date of service. In particular,

1. It is my responsibility to pay for all services at the time they are provided. I am also responsible for any non-reimbursed costs, which may include, but are not limited to: deductibles, copayments, missed sessions, unauthorized sessions, and non-covered procedures. I understand that I will be responsible for making prompt payment for any charges subsequently denied by my insurer.
2. I understand that Dr. Spaine's office provides insurance filing as a courtesy and a convenience to me and will seek authorizations (beyond the initial authorization) from my insurance provider; however, these activities do not guarantee that my insurer will pay.
3. I understand that Dr. Spaine's staff will provide me with an estimate of my expected fees based upon information from my insurer, however, until actual remittance is received from my insurer, this information can only be considered an estimate. I understand that I will be responsible for any charges that the remittance reflects that I owe, and conversely, I understand that I will be refunded any amounts I may have been overcharged.
4. I understand that I am free to file my own insurance with paperwork and diagnosis given by Dr. Spaine. In this case, full payment of fees is required of me at the time of service and my health insurer will provide reimbursement directly to me in accordance with my insurance plan specifications, if applicable.
5. **My account may never be over \$300.00 in arrears.**
6. I understand that I am responsible for meeting the requirements of my health insurer or managed care provider. In particular, I am responsible for:
 - a. Obtaining the **initial referral** to Dr. Spaine, if needed.
 - b. Ensuring I have **pre-certification** of visits, if needed.
 - c. Knowing limits regarding my **deductible**.
 - d. Keeping track of **benefits limits**. Keeping track of my benefits entails knowing any limits on my policy and ensuring that I do not exceed those limits (e.g., some insurers set a maximum of 20 mental health sessions per year). If I exceed my limits and my insurer refuses to pay, I will be responsible for the amount refused. Also, I understand that if I am seeing another psychologist or psychiatrist, those sessions may count against my mental health benefits. I also realize that while my managed care provider may authorize visits as appropriate for me, that does not mean that they will necessarily pay for those visits (e.g., some insurers will authorize 35 visits, but they will only pay for 30 visits).
7. I also understand that if my policy changes or if I switch insurance companies, I should inform Dr. Spaine's office staff immediately. If Dr. Spaine's office does not have the proper information to file claims with the appropriate insurer, I am responsible for the amount the insurance company will not pay.

IRBP81110

Fayetteville Psychotherapy Associates is not a partnership or joint venture. It is an unincorporated association of practitioners, each of whom is an independent contractor.

8. I must provide 24 hours notice of cancellation for appointments scheduled with Dr. Spaine or I will be charged the *full session fee* (\$150) for the missed session (except in cases of emergency). Insurance companies do not reimburse for missed sessions.

I, _____, have read and understand the above insurance and payment policies outlined above. I understand and agree that I am responsible for the cost of all services not covered by my insurance plan.

I hereby authorize Fayetteville Psychotherapy Associates, PLC and its agents to submit health insurance claims for all services and receive direct payment from my insurance carrier. I authorize Fayetteville Psychotherapy Associates, PLC and its agents to release information from my record that pertains to filing and providing adequate documentation for any insurance claim. It is my responsibility to notify Fayetteville Psychotherapy Associates, PLC in writing if I do not want my claims submitted in the future. I understand this consent has no expiration date.

Client Signature (or guardian if client is a minor)

Client Printed Name

Date

Witness Signature