INTEGRATED
BEHAVIORAL
HEALTH
psychological services

FINANCIAL AGREEMENT

Patient's Name: _____

We ask that patients and their families work with us with an understanding that deductibles and co-pays need to be paid. Insurance coverage does not guarantee payment for all services.

IBH Psychological Services has verified insurance eligibility and benefits with your insurance carrier: _____.

- However, insurance verification is not a guarantee of coverage and/or payment. Your insurance carrier determines payment upon receipt of each claim.
- As a courtesy, IBH Psychological Services will submit claims twice.
- If a claim is not paid, you are responsible for payment.
- If your deductible has not been met, patients will be asked to pay a portion of their deductible at every visit. This amount will be based on payment history from your insurance carrier.
- You are responsible for your co-payment or co-insurance **prior** to the start of each office visit.
- We accept cash, personal checks, and credit cards.

FOR SELF-PAY PATIENTS:

I agree to pay $_____ per session. Payment will be made at each visit.

I understand all the above information and will pay accordingly if needed.

Patient Signature: _____ Date: _____

If patient is **under 18 years of age** (or over 18 years of age and has a legal guardian):

Parent/Guardian Signature: _____ Date: _____

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