Thomas Joseph Doherty, Psy.D., Licensed Psychologist
Billing Information and Fee Agreement

Client Information – If the financially responsible person is other than the patient, please complete page 3 of this form.

Name: _____ Date of Birth: _____

First Middle Last

Gender: M __ F __ Age: ___ Marital Status: _____ SSN: _____

Address: _____ City, State, Zip: _____

Telephone(s): _____ _____ _____

(home) (cell) (work)

E-mail 1: _____ e-mail 2: _____

May we leave messages for you? □ on home phone □ on cell phone □ on work phone □ on email □ No

Fees

Initial Telephone Consultation	No Charge	30 minutes
Intake Session / Diagnostic Interview	250.00	80 minutes
Individual Session	165.00	50 minutes
Family / Couples Session	185.00	50 minutes
Group Session	55.00	80 minutes

Financial Policies

- **Session Fees:** Fees for Intake Session/Diagnostic Interviews are due in full at the time of session. All other session payments are due in full by cash, check, or credit card at the time of the session unless prior arrangements are made.
- **Additional Service Fees:** Telephone sessions or consultations are billed at the individual session rate on a prorated basis. Preparation of reports or letters will also be billed on a prorated basis at the individual session rate. All professional services related to legal proceedings are billed at $250.00 per hour.
- **Cash payment discount:** Clients paying in full at the time of service without using insurance are entitled to a 20% self-payment discount. There may be other benefits of cash payment, including increased confidentiality and freedom from using a mental health diagnosis. Please discuss this with Dr. Doherty.
- **Insurance Reimbursement:** If you are using health insurance benefits, you need to be aware of your policy and its benefits and limitations. All policies are different. All payments are **due in full at the time of service** until insurance coverage is confirmed. Otherwise, co-payments are due at the time of the session. Insurance payments will be applied to your balance. Positive balances are applied to future co-payments or refunded.
- **Late fees:** A late cancellation fee of $80.00 will be charged for sessions missed without 24-hour notice (Friday notice for Monday appointments). Insurance companies do not pay for missed appointments, so you are financially responsible for them.
- **Delinquent Accounts:** All balances outstanding after 90 days past due will be billed to your credit card. If an account is seriously delinquent, I will provide 30 days notice prior to referring the matter to a collection agency. If missed appointments are a recurring problem, I may ask for a retainer before scheduling the next appointment.

Payment Plan

_____	I agree to pay the session fee or insurance copay in full at the time of service (cash or check).
_____	I request that my credit or debit card be charged for each session fee or insurance copay at the time of service.
_____	I request that my credit or debit card be charged monthly for session fees or insurance copays.

Credit Card Information

I authorize Thomas Joseph Doherty, Psy.D. to charge this account for services according to the financial policies and payment plan above.

Type of card: Visa MasterCard Debit Account Number: _____

Exp. Date: _____ Security Code: _____ Billing Zip Code: _____

Name of card holder: _____ Signature: _____

Address (if different than above): _____

Insurance information – Please provide a copy of your insurance card(s), front and back

Primary insurance carrier: _____ Phone: _____

Claims address: _____

Name of insured: _____ Relationship to patient:_____

Insured ID number: _____ Group number: _____

Insured date of birth: _____ Phone: _____ Employer: _____

Insured's address: _____

Secondary Insurance Carrier: _____ Phone: _____

Claims address: _____

Name of insured: _____ Relationship to patient:_____

Insured ID number: _____ Group number: _____

Insured date of birth: _____ Phone: _____ Employer: _____

Insured's address: _____

- I understand the financial policies established by Thomas Joseph Doherty, Psy.D.
- I understand I am financially responsible for all charges, regardless of insurance, unless otherwise written by Thomas Joseph Doherty, Psy.D.
- I hereby authorize the release of all health care information necessary to process an insurance claim.
- I hereby authorize my insurance carrier to make payments directly to Thomas Joseph Doherty, Psy.D.
- I understand that balances left unpaid over 90 days from the date of service may be charged to my credit card.
- Past due fees may also assessed a 1.5% rebilling/past-due account fee (minimum $5.00) per month and/or may be referred to a collection agency to facilitate payment.

Client Signature: _____Date: _____

Complete this section if the financially responsible person (Guarantor) is someone other than the client

Name: _____ Date of Birth: _____
First Middle Last

Gender: M __ F __ Age: ___ Relationship to Patient : _____ SSN: _____

Address: _____ City, State, Zip: _____

Telephone(s): _____ _____ _____
(home) (cell) (work)

E-mail 1: _____ e-mail 2: _____

May we leave messages for you? □ on home phone □ on cell phone □ on work phone □ on email □ No

- I hereby authorize the release of all health care information necessary to process an insurance claim.
- I hereby authorize my insurance carrier to make payments directly to Thomas Joseph Doherty, Psy.D.
- I understand I am financially responsible for all charges, regardless of insurance, unless otherwise written by Thomas Joseph Doherty, Psy.D.
- I understand the financial policies established by Thomas Joseph Doherty, Psy.D.
- I understand that balances left unpaid over 90 days from the date of service may be charged to my credit card. Past due fees may also assessed a 1.5% rebilling/past-due account fee (minimum $5.00) per month and/or may be referred to a collection agency to facilitate payment.

Signature: _____ Date: _____