Scott A. Kaplan, PhD, Psychologist, P.C. *Counseling & Consulting*
Licensed Clinical Psychologist *(c)312-882-3344*

Services and Payment Agreement

PLEASE NOTE: *While insurance or another person may be paying for all or part of your charges, this payment agreement is with you rather than the insurance company or the person paying for your therapy. Your signature below indicates your understanding and willingness to abide by the following policies:*

- *Payment of all reasonable charges involved in the rendering of services*
- *Payment of co-payments or full fee, up to billed charges, at the time of each visit unless other arrangements have been made in advance. This includes situations where there is a 3-month grace period to pay your premium and your health care coverage terminates at the end of the grace period, yet you received services after coverage terminated.*
- *Payment of $120 for each scheduled appointment you do not keep or cancel with at least a 24-hour notice*

If you believe your medical insurance may cover the costs of all or part of your services, please provide a copy of your insurance card and complete the following information:

Policy Holder	*Insurance Company or Plan*	*Identification/Policy Number*
Group/Enrollment Number	*Relationship to Client (if different)*	*Policy Holder's Date of Birth*
Policy Holder's Phone Number	*Policy Holder's Address (if different)*	

I will file your insurance claim for you, unless your insurance company requires otherwise. However, ***you are strongly encouraged to contact your insurance company before your first session*** *to ask them for information regarding your co-payment and deductible for "outpatient behavioral health services." This will help you determine the appropriate payment or co-payment for your counseling sessions.* ***All self-pay payments and co-payments must be paid at the beginning of each session.*** *If your insurance plan requires a physician's referral, please contact your doctor before your first session.*

AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH INFORMATION AND AGREEMENT TO PAY

I, _____ *on my own behalf authorize* ***Scott A. Kaplan, Ph.D.*** *to release mental*
CLIENT'S NAME
health information to my insurance company to the full extent specified under any or all Federal and State laws, or as subsequently amended, to provide utilization review and quality assurance service for the administration of claims for benefits. I further authorize ***Scott A. Kaplan*** *to directly receive all payment of benefits due, unless I am responsible for payment of services rendered.*

This authorization allows ***Scott A. Kaplan*** *to release information to my insurance company, to administer claims submitted, or to be submitted for payment, to conduct a utilization and quality control review of mental health care services provided or proposed to be provided, or to conduct an audit of claims paid.*

I acknowledge that I am aware that I may inspect the information disclosed at any time, and may revoke this authorization at any time if I provide written revocation to ***Scott A. Kaplan*** *and thus, I agree to accept financial responsibility for mental health care services provided if my insurance should deny claims for benefits because of the inability to examine my mental health records.*

I certify that all the information is true, accurate, complete, and I agree to be personally responsible for all reasonable charges not paid by my insurance company.

_____		_____
Client Signature	*Date*	*Social Security Number*
_____		_____
Parent/Guardian Signature	*Date*	*Social Security Number*