Montana City Counseling

Michael A Emerson, Ph.D.

Payment Contract for Services

Name(s): _____
Address: _____ City: _____ State: _____ Zip: _____

Bill to: Person responsible for payment of account: _____
Address: _____ City: _____ State: _____ Zip: _____

FEDERAL TRUTH IN LENDING DISCLOSURE STATEMENT FOR PROFESSIONAL SERVICES

FEES FOR PROFESSIONAL SERVICES

Your insurance will be billed per clinical unit and payment accepted per authorized preferred provider contract. You are responsible for your co-payment and medical deductibles.

I (we) agree to pay **Dr. Michael A Emerson, Montana City Counseling Center** the Standard Insurance acceptable rate per clinical unit (defined as 60 minutes for assessment, testing, medical/therapeutic collaboration as well as individual, family and relationship counseling). The fee for testing includes scoring and report-writing time.

A fee of $125.00 is charged for missed appointments or cancellations with less than 24 hours' notice.
A fee of $187.00 per hour is charged for services not covered by insurance, such as extra report writing time, and any other services not covered by insurance. Court appearances will be charged at the rate of $250.00 per hour.

CO-PAYMENT'S AND DEDUCTIBLES ARE YOUR RESPONSIBILITY

If your deductible has not been met at time of office visit, you will be billed per hourly unit until deductible has been met.

- **Co-payment's will be due at time of visit.**

We suggest you confirm these provisions with the insurance company. The Person Responsible for Payment of Account shall make payment for services that are not paid by your insurance policy, all co-payments, and deductibles. We will also attempt to verify these amounts with the insurance company.

Your insurance company may not pay for services that they consider to be non-efficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance

- **Payments, co-payment's, and deductible amounts are due at the time of service. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.**
- **Credit Cards of Visa and Master charge are accepted for Co-payment and Deductible**

. _____ I would like to use the Credit Card option for payment of my Co-pays and Deductible.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person(s) responsible for account: _____ Date: _____/_____/_____