Linda Dreke, Ph.D., Licensed Psychologist
Oak Ridge Psychotherapy Practice
679 Emory Valley Rd., Suite B, Oak Ridge, TN 37830
Ph: 865-212-6018; Fax: 865-220-0782

FINANCIAL AGREEMENT FOR PROFESSIONAL SERVICES

Psychological services provided to you by Dr. Linda Dreke may be totally or partially covered by insurance or some form of managed care. Or, if you are uninsured or do not wish to pay with insurance, you may pay using Dr. Dreke's sliding fee option.

If you plan to submit the bill for services to insurance, you must arrange to do so **before** we begin the services. Many insurance contracts require authorization of services before the services are provided. Such contracts deny payment for services when pre-authorization has not been obtained. It is *your responsibility* to obtain pre-authorization. Because there are so many differences among insurance contracts, if you plan to file a claim, we must know the specifics of **your** insurance before we begin providing services. As a courtesy and so that we know what to expect, we generally call to double check your insurance benefits. However, please understand that decisions about coverage are made by your insurance company. Your insurance company can help you to understand the procedures for obtaining coverage. It is your responsibility to work this out with your insurance company.

Please note that in some cases, the requested services will not be covered by insurance (i.e., school meetings, school observations, educational testing). If you have any questions about what is likely to be covered, please be sure to address these issues with us and your insurance company in advance. Because the insurance scenarios have become so variable and complex, please read this agreement carefully to be certain that you understand which type of financial agreement applies to you and what your particular responsibilities are. Once treatment terminates, any balance not paid in full will be considered due. **Read the following sections carefully and make your selection by initialing in the appropriate place on page 2.**

CANCELLATION POLICY

Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation (by phone call or email), unless we both agree that you were unable to attend due to circumstances beyond your control. When cancellations occur, we will either find another time to reschedule the appointment or resume with the next regularly scheduled appointment time. Since insurance companies do not typically pay for cancelled appointments, you will be required to pay the *full cost of the appointment* (see "Fees for services" section below) and your insurance company will not be billed. If you are on a sliding fee scale, you will be required to pay your usual sliding fee rate.

FEES FOR SERVICES

For those who are using insurance and paying out-of-pocket until insurance deductibles are met.

Payments for services are due at the time service is rendered. The fees for clients filing insurance (whether in-network or out-of-network) are:

- Initial consultation = $130.00 per 60- minutes;
- Ongoing individual psychotherapy = $100.00 per 50-minutes;
- Family therapy = $100.00 per 50-minutes;
- School and other off-site meetings/observations are typically billed at $130.00 per hour, and are often not covered by insurance. Time in excess of standard sessions is prorated.
- Fees for home visits need to be arranged separately.
- Fees for testing vary by the type of assessment needed, and are discussed in a separate form.

Charges are based on the amount of professional time utilized. If additional time or services (e.g., telephone calls lasting more than ten minutes, reports, treatment plans, or letters) are provided, a prorated fee will be charged. When requesting any service it is best to inquire what the charge will be.

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PAYMENT OPTIONS:

1) INSURANCE (NON-PROVIDER; "OUT-OF-NETWORK")
If I will be filing with insurance but am not a participating provider in your insurance plan.

If you have insurance coverage and wish to use it, you should contact your insurance representative to obtain coverage information. The insurance contract is between policy holder and insurance company and not between provider and insurer. We will assist you by submitting claims electronically for each session, and will likely call your insurance company to double-check your benefits. You are responsible for paying Dr. Dreke (by cash or check) at each session. The amount will vary depending on your individual plan's deductible, co-pay, etc. As part of this process, the primary client will be given a diagnosis, in order to establish the medical necessity of therapy.

2) INSURANCE (PARICIPATING PROVIDERS; "IN-NETWORK")
If I am a participating provider in your insurance plan.

Fees are reimbursed at the Usual and Customary rate allowed by our contract with your insurance company. Provided that services have been properly pre-authorized, you are responsible for the co-payment which you are expected to pay at the time of service. Often, the amount is a percentage of the contracted fee. This percentage may change as determined by your insurance. If your deductible has not yet been satisfied, you will need to pay the full fee for each session until it is (fees are listed on page 1). We will bill your insurance company for their portion of the fee.

Some services may not be covered under the mental health benefit of your insurance contract. Those services which you have requested, and which are not a covered benefit, will be billed directly to you. Those services might include things like Dr. Dreke attending a school meeting, doing a home visit, or conducting a school observation, at your request.

3) SLIDING FEE SCALE
If you are uninsured or choose not to use your insurance. You must complete the sliding fee scale fee on pg. 4 and your ongoing rate will be determined based on your total family income. The intake appointment for all sliding fee clients is $75.

Please initial one of these three financial arrangements (which have been explained above), indicating the appropriate option for you.

____ INSURANCE (NON-PROVIDER) *If we are not providers in your insurance plan ("out-of-network").*
____ INSURANCE (PROVIDER) *If we are providers in your insurance plan ("in-network").*
____ SLIDING FEE SCALE *For those who are paying out-of-pocket. Cost per session will be determined by your family's income and insurance will not be filed. *Complete form on pg. 4*.*

My signature below indicates that I have read and understand this fee policy. I agree to take responsibility for fees in accordance with my selection of options in Section 1.

_____ _____
Signature Date

_____
Employer (of primary insured, if using insurance)

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Sliding Fee Scale Form

**** This form is ONLY to be completed by clients choosing NOT to file insurance*****

Household Income: Information used solely to determine weekly fee for treatment. Please complete the form below honestly and to the best of your ability. Dr. Dreke reserves the right to request financial forms (e.g., W-2, paystubs, etc.) to verify the information, if needed. Please include income for all individuals in the household and income from other sources, including: gross wages, tips, social security, public aid, disability, pensions, net business or self employment, alimony, child support, unemployment, and other.

Name	Amount	Frequency (Circle one)	Employer:	Occupation/Trade:
You	$	Weekly Monthly Yearly		
Spouse	$	Weekly Monthly Yearly		
Children	$	Weekly Monthly Yearly		
Other	$	Weekly Monthly Yearly		
Other	$	Weekly Monthly Yearly		
TOTAL	$	Weekly Monthly Yearly		

Total # of Household members: _____

Based on the gross household income and number of household members, we agree that the regular session fee for therapy is:

$_____ (per 50 minute session). Parent/Guardian Initials: _____ Psychologist Initials: _____

- I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and could result in termination of services. I agree to inform Dr. Linda Dreke if there is a significant change in my income.
- I agree to submit payment for services rendered at the end of each 50-minute session. I understand that payment may be rendered by cash or check (to "Dr. Linda Dreke"), with receipt provided for my personal records.
- I understand that I am agreeing not to use insurance to pay for sessions. If I later wish to begin using insurance for payment, I will sign a new agreement with Dr. Dreke.
- I understand that I will be responsible for paying the above rate if I miss an appointment without providing the appropriate notice.
- I acknowledge that additional services (school observations, testing, and attending school meetings) are generally billed at a higher rate and must be agreed upon with Dr. Dreke prior to those services being rendered.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____
Signature Date

_____
Printed Name

My signature below indicates that I have gone over this form with you and encouraged you to read over it in detail on your own and ask questions as needed.

_____ _____
Service Provider Signature Date