Jonina D. Bolton, Ph.D.
Licensed Psychologist

REVISED FINANCIAL POLICY AND AGREEMENT

Client Name(s):_____ **Date of Birth:** _____

Name of Primary Insurance Holder: _____ **Date of Birth:** _____

The client, or responsible/accountable party (if the client is a minor), is responsible for paying the fee at the time that services are rendered. If you plan to utilize insurance benefits, then please notify Dr. Bolton of your intention to do so, in advance. Dr. Bolton will submit insurance claims on your behalf to companies for which she is an in-network provider only. However, in the event that the claim(s) are denied by your insurance company, you will be held financially responsible for paying the fees in-full and for seeking reimbursement from your insurance company.

If the client or responsible party has scheduled an appointment and chooses for any reason not to use that appointment time, then twenty-four (24) hours notice is required. If inadequate notice is given, or if a client does not show for an appointment that he/she has reserved, then the client or responsible party will be charged **$50.00** and will be held financially responsible for paying the fee. Insurance companies do not pay any portion of the fee for a missed or cancelled appointment. I understand my financial responsibility for reserved appointments, including my responsibility to notify Dr. Bolton with at least 24-hour notice to avoid being charged a fee of $50.00. **Please initial here**. _____

The client or responsible party is required to guarantee payment for services used. In the event that any collection procedures become necessary, the client is responsible for all fees for services rendered, interest accrued, document preparation time, photocopying fees, and all costs of collection, including attorney fees and court fees.

Having been notified of these terms, I/we agree to the following fee arrangements:

EAP services: no co-pay for # _____ sessions (initial here) _____

Insurance pay: Deductible _____

Co-pay of $ _____ per therapy session (initial here) _____

Co-insurance of % _____ per therapy session (initial here) _____

Private pay fee of $_____ per therapy session (initial here) _____

Private pay fee of $_____ per hour of testing (initial here) _____

Private pay fee of $_____ other _____ (initial here) _____

Client Signature(s): _____ **Date:** _____

_____ **Date:** _____

Jonina D. Bolton, Ph.D.:_____ **Date:** _____

*Signature on File: I authorize the release of any clinical information necessary to process claims made on my behalf or that of my family member(s). Please accept a photocopy of this authorization as if it were an original. My signature below acts as the signature on file.

Signature: _____ **Date:** _____

*Assignment of Benefits: I hereby authorize and direct payment of insurance benefits to Jonina D. Bolton, Ph.D. for professional services rendered. I understand that I am financially responsible for all charges not covered by this assignment.

Signature: _____ **Date:** _____

4731 Highway A1A
Vero Beach, Florida 32963
(772) 234-7100