

CLIENT INFORMATION & FINANCIAL POLICY

I request that the therapist named below provide professional services to me or to _____,
Who is my _____. I agree that I am responsible for charges for services provided by my therapist to me (or this
client), although other persons or insurance companies may make payments on my (or the client's) account.

MINORS: The parent/guardian/adult accompanying a minor child is responsible for full payment. If both parents have insurance,
the insurance policy must be verified to determine which company is primary before the appointment. In divorce cases,
Psychological Services of Jacksonville, LLC (PSOJ) will bill participating insurances, but the parent who brings the child for services
is ultimately the responsible party.

Insurance companies handle behavioral health services differently than medical or surgical services; therefore, it is important to
become as knowledgeable as possible about my insurance plan. **My portion of payment is due at the time of service.**

As a courtesy, PSOJ will file claims with my insurance company. PSOJ will bill most secondary companies for me provided I have
presented all insurance information. If PSOJ is contracted, they will accept as payment in full the insurances allowable amount. My
insurance policy is a contract between myself and my insurance company. If I have given PSOJ all the required information, they
can submit the mental health services to the insurance companies with which my therapist is contracted. I need to be aware that
some services may be "non-covered" services according to my policy. I am still responsible for payment of services rendered. I am
responsible for notification of any benefit changes within my policy plan.

I understand that I am financially responsible for co-payments, co-insurance amounts and deductible amounts. If my policy has a
co-payment, I am required to pay at the time of service. Full payment is due at the time of service. PSOJ accepts cash, checks
and credit cards.

Medicare: PSOJ accepts Medicare assignment. Which means Medicare will pay their office directly. If the provider is not
contracted with my supplemental insurance company, PSOJ will bill my insurance **one time as a courtesy**. If a payment is not
received within 30 days, I may be billed the balance up to Medicare's allowable amount.

Mental health care requires collaborative effort of both myself and my therapist. When I do not come to my scheduled appointment
or cancel my appointment without the required **24-hour notice**, not only do I miss an opportunity for treatment, but I also deny
someone else the opportunity as well. To be scheduled in a timely manner and allow for timely follow-up appointments, it is my
responsibility to communicate when I am unable to keep my appointment not only as a courtesy to my provider and other patients,
but also for administrative purposes as PSOJ staff prepares for each and every visit. Whenever possible, a courtesy call will be
made to remind me of my appointment, however, I am ultimately responsible for keeping my appointments. **Consequently, late
cancellations and missed appointments may be subject to a \$75.00 fee and payment will be expected on or before my next
scheduled appointment.** Insurance companies do not pay for either late cancellations or missed appointments. **I am responsible
for my scheduled appointments even if I do not receive a reminder call from the office. If I no-show three consecutive
appointments without contacting the office, the therapist will consider me to be self-terminated from treatment. Also, if 90
days pass without scheduling an appointment (unless this break is part of my treatment plan with my therapist), the
therapist will consider me to be self-terminated from the current course of therapy.**

Any returned check for insufficient funds will result in an additional fee of \$35.00. Medical record releases requested by other
providers faxed on my behalf are at no charge. Complex forms requested to be filled out by my provider on my behalf may incur
additional fees depending on time required for completion. This does not pertain to insurance prior authorizations. I may present
my documents and the PSOJ staff can access whether fees will be incurred.

Failure to meet any financial responsibilities in a timely manner may result in termination of treatment with Psychological Services of
Jacksonville, LLC. If I ever have any questions about bills that I receive, or I have the need to make payment arrangements due to
hardship, loss of insurance, job, or other, I may contact the office and they will be happy to assist me with my options for continuing
my care. Due to the high volume of appointments being made, I am encouraged to schedule my follow-up appointment before
leaving the office. This is the only guarantee I will get an appointment as the therapist has recommended. Waiting to schedule my
appointment may result in a long delay between sessions.

Printed Name

Relationship

Signature of Client or Guardian

Date

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the
client's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing
consent.

Signature of Therapist

Date