Behavioral Health Affiliates, LLC

84 High Street, Suite 2A • Medford, MA 02155 • (781) 393-0009

FINANCIAL AGREEMENT

Date: _____/_____/_____

Patient Name: ___________________________________

Insurance Company: ________________________________

Authorization #__________________________________

Fees:

Initial Evaluation	$____________
Psychotherapy Therapy (45 minutes)	$____________
Late Cancellation/No Cancellation	$____________

Payment Policy:

- Out-of-pocket payments are due at time of service unless there is a special arrangement defined in advance.
- Insurance payments are accepted per contracted fee schedule.
  Patients are responsible for co-payments and deductibles that are established by their insurer.
- If an appointment is cancelled with 48 hours notice there will be no charge. If there is a late cancellation or the patient fails to attend a scheduled appointment the patient will be billed as shown under fees listed above.

I assign payments to this office from my insurer for services rendered to me, or my dependents by

____

(NAME OF CLINICIAN)

Signature: ________________________________ Date: _____/_____/_____

I agree to pay any co-payments and/or deductibles that are established by my insurer.

Co-payment = $________

Deductible = $________

Signature: __________________________________ Date: _____/_____/_____

It is my (patient/parent or guardian) responsibility to know my insurance benefits. Therefore,
I am responsible for any non-covered services rendered to my dependent or me.

Signature: __________________________________ Date: _____/_____/_____