Mayo Psychological Services

Financial Policies

Our goal is to make sure your experience here is delivered with thoroughness and with the utmost quality. We want to keep your insurance and/or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1. It is your responsibility to provide us with your current address, telephone numbers and insurance information at each visit.

2. It is your responsibility to contact your insurance carrier to confirm that we participate in your specific plan.

3. All co-payments are due at the time of service. Any accounts with outstanding co-pays will be assessed a $25 fee for failure to pay at the time of service.

4. A late cancellation fee will be charged for appointments not cancelled within 24 hours of the scheduled time.

5. There is a $25 fee for checks not honored by your bank.

6. There will be a fee for completion of forms such as disability, FMLA, employer forms, etc. This fee is determined by the amount of time needed to complete these documents and will be discussed with clients upon the request for completion of forms.

7. All professional services rendered are charged to the client/responsible party. Insurance may or may not pay for your therapy appointment, testing or assessment. Insurance reimbursement rates, deductibles (individual or family) and levels of authorized care often vary between plans and companies. Filing your insurance is NOT a guarantee of payment. **You, as the client, are responsible for all fees – regardless of insurance coverage.** Insurance billing, treatment plans, etc. are filed as a courtesy for in-network clients only. The client/responsible party is required to pay for services when rendered unless other arrangements have been made in advance.

8. Dr. Mayo only accepts cash or check for co-pays. Special arrangements can be made for employee health funds.

I, the undersigned, have read, understand and agree to the aforementioned responsibilities and fee requirement s indicated.

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Please Print Name

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Patient Signature

_____

Date