Randi Most, Ph.D., ABN
Board Certified Neuropsychologist

PAYMENT ARRANGEMENTS AND NOTIFICATION OF PRIVACY PRACTICES

Patient Name ____

PROFESSIONAL FEES AND MISSED APPOINTMENTS

My hourly fee ranges from $125-$200 per hour. In addition to scheduled appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, filling out forms, and the time spent performing any other service you may request of me. You will be charged $25 if you do not provide 12 hours notice of a cancelled therapy appointment. You will be charged a $50 rescheduling fee if less than 24 hours notice is given for cancellation of a neuropsychological evaluation (unless, in either situation, we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled appointments. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $200 per hour for preparation and attendance at any legal proceeding.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, it's costs will be included in the claim.

INSURANCE REIMBURSEMENT

I will submit insurance forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however you, not your insurance company, are responsible for full payment of my fees. It is very important that you find out exactly what mental health and/or medical services your insurance policy covers. You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. Although all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. By signing this Agreement, you agree that I can provide any requested medical, psychological and/or neuropsychological information to your carrier, or it's agents, if required for determination or payment of benefits. You are also assigning benefits to me for any clinical services that I provide.

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FL License #PY4903 GA License #PSY1141

THE TERMS OF THIS AGREEMENT CANNOT BE CHANGED, DELETED, OR AMENDED. YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

_______________________________ _______________________
Signature of Responsible Party Date

_______________________________ _______________________
Print Name SSN

_______________________________ _______________________
Street Address Phone

____
City, State, Zip

ACKNOWLEDGMENT OF RECEIPT OF PATIENT NOTIFICATION OF PRIVACY PRACTICES

I understand that I can obtain a copy of Dr. Most's "Notice of Policies and Practices to Protect the Privacy of Your Health Information", detailing how my information may be used and disclosed as permitted under federal and state law, from her website www.rmost.com or by requesting a paper copy. I understand the contents of the notification. HIPAA requires that Dr. Most obtain your signature indicating that you have been informed how to gain access to this document. Your signature below does not surrender any rights or confidentiality.

_______________________________________ _______________________
Patient or Guardian Signature Date