

REGISTRATION POLICIES AND FINANCIAL AGREEMENT

Fees: for Psychotherapy (45-50 min):

Director: Dr. Katie O'Meara \$200.00

Associates:

Dr. April Simcox: 185.00

Dr. Adam J. Sowa: 180.00

Dr. Kyla Aimone: 175.00

Dr. Emily Rotbart: 170.00

Dr. Noura Khayat: 165.00

Leslie Coates Burpee, M.A., NCC, CCTP: 165.00

Susannah Harrison, M.A., LPC: 165.00

The following services are prorated based on the therapist's fee.

Psychotherapy (20-25 min)

School Observation (50 min)

Extended Session (90 min)

Preparation of Report (50 min)

*All school consultations and off-site meeting include time spent at location + travel time to and from (based on Alexandria or Falls Church office location).

Case Management Fees

Phone contact more than 10 minutes is billed at a prorated fee based on therapist's rate. Phone contact includes communication with client, schools, other providers, etc. Additionally, staff will spend up to 30 minutes communicating with your insurance company at no charge. This time includes phone time, paperwork, etc. Any extra time is billed based on therapist's rate.

Payment

I understand that payment in full at each visit. Payment may be made by check, cash or credit. I understand and agree that I am charged directly and am personally responsible for payment of all services rendered to me (or the minor for whom I am responsible). I understand that the fee for returned checks is \$40. I agree that if I default on payment, I will pay collections costs, attorney fees, and any and all court costs resulting.

Cancellations



I understand that I will be charged the full fee for any appointment missed or cancelled without giving a 48-hour notice. I understand that my insurance company will not reimburse costs incurred from an appointment missed or cancelled without sufficient notice.

Insurance

I understand that the Center for Cognitive Therapy and Assessment does not participate with any health insurance plans. I understand that I am responsible for submitting claims for reimbursement with my insurance carrier. I understand that some procedures such as, but limited to, missed or late appointments, preparation of reports, and telephone consultations may not be reimbursable by an insurance company and are solely my responsibility.

Billing/Invoices

I understand that invoices will be mailed or delivered to me on a monthly basis. **Please keep your invoices.** Requests for replacement of invoices or itemized bills will be subject to a \$15.00 charge.

Responsibility

I have read and agree to the above information. My signature below indicates that I both understand and agree to these policies.

Signature of Responsible Party

Date