PATS
PSYCHOLOGICAL ASSESSMENT & TREATMENT SERVICES, LLC
FOSTERING CHANGE, FOSTERING GROWTH

Daniel A. Patz, Psy.D., L.M.H.C.
Licensed Psychologist
Licensed Mental Health Counselor

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Licensed Mental Health Counselor

Financial Responsibility

Important information regarding your account

Statement of Financial Responsibility

I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred.

Notice of “non-covered” Services

I am aware that at times insurances may consider some services as “non-covered” by the insurance carrier, Medicare or Medicaid, therefore I will become fully responsible for payment of these services.

Waiver of “Usual, Customary, and Reasonable” Clauses (for patients with “out of network” coverage).

I acknowledge that the fee charged by the Practice for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered “usual, customary, and reasonable,” due to specialized services by our clinician. However, I agree to pay the Practice fees in full, even if the amount is greater than what I am reimbursed from my insurance company.

I understand that as part of my treatment, payment or health care operations, it may become necessary to disclose health information to another entity, e.g. referrals to other health care provider. I understand that my information may be used or disclosed, without an authorization as permitted or required by law.

_____________________________________ _________________________________

Parent/guardian signature **Date**

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Print name of person signing

If other than the patient (Patient name) ____

Is signing, are you the legal guardian, custodian, or have Power of Attorney for this patient, for treatment, payment or health care operations? Yes or No

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