Joel D. Carnazzo, Psy.D.

550 Fox Glen CT
Barrington, IL 60010
847-381-5001 (o)
847-381-5059 (f)

Financial Contract

This contract outlines my financial and business policies. My fee is $175 for initial intake assessment and $155 for therapy sessions. Payment is usually expected at the end of each session in the form of cash, check, or credit card. My professional services are covered by Blue Cross/Blue Shield PPO, Cigna, ComPsych, and Medicare. BCBS PPO, Cigna, ComPsych or Medicare participants will be billed for co-payments and deductibles after receiving a benefits summary. Any designated co-payments and/or deductibles are your financial responsibility.

If you have other insurance, it may cover services for out-of-network providers. It is your responsibility to contact your insurance company to access information regarding your mental health benefits. If your health insurance will pay part of my fee, I will complete a monthly statement that you can submit to your insurance for reimbursement. However, you are ultimately responsible for payment at the time services are rendered.

If you think you may have trouble paying your bill on time, please discuss this with me so we can arrive at a solution. If your account has not been paid for more than 60 days and arrangements have not been made, a collection agency may be utilized to secure payment.

Payment Method: ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance

Insurance Information (Please complete or provide copy of your insurance card):

Insurance Company: ____

Subscriber Name: ____ Subscriber DOB: _____________

Identification/Policy #: ____

Group or Enrollment #: ______________________________

Insurance. Co. Phone: _______________________________

PLEASE INITIAL:

_____ *Financial Relationship*

I agree that a financial relationship with this therapist will continue as long as the therapist provides services to me. I agree to pay for services provided through the termination of services.

_____ *Accepting financial responsibility*

I understand that I am ultimately responsible for the services provided by this therapist to me, although other persons or insurance companies may make payments on my account.

_____ *Authorization for release of information for billing purposes*

I hereby authorize the release of any information necessary for third-party submission and/or payment for services. I authorize payment of third-party benefits to Joel D Carnazzo, Psy.D. for mental health services described herein.

_____ *Cancellation Policy*

Any cancellations of appointments must be made at least 24 hours in advance of the scheduled session. If I do not call to cancel and/or fail to show, I will be charged $155 for that appointment.

______________________________________	______	________________________________	_______
Signature of Client (or person assuming financial responsibility)	Date	Joel D. Carnazzo, Psy.D. Licensed Clinical Psychologist	Date