Maureena Benavides, M.A., LPC

Payment Contract for Services

Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Bill to: (Person responsible for payment of account): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Federal Truth in Lending Disclosure Statement for Professional Services

Part One Fees for Professional Services

I (we) agree to pay Maureena Benavides, hereafter referred to as the clinic:

A fee of $ 90 per clinical session either in person or by phone (defined as 45–50 minutes for assessment, testing, and individual, family and relationship counseling).

A fee of $ 45 is charged for group counseling. The fee for testing includes scoring and report-writing time.

A fee of $ 45 is charged for missed appointments or cancellations with less that 24 hours’ notice.

A fee of $ 90 per hour is charged for services not covered by insurance, such as court appearances, extra report writing time, and any other services not covered by insurance.

Part Two Clients with Insurance

 Cash or check payment is due at the time of service. If you provide forms from your insurance company for reimbursement, our office will fill out the clinical portion. Your insurance company may not pay for services that they consider to be non efficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). Ultimately the responsible party must pay for services and get reimbursed by the insurance company. The amounts charged for professional services are explained in Part One above.

Part Three All Clients

Payments are due at the time of service. I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Release of Information Authorization to Third Party

I (we) authorize Maureena Benavides to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above-listed third-party payer or insurance company for the purpose of receiving payment.

I (we) understand that access to this information will be limited to determining insurance benefits and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Person(s) receiving services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_