Michael S. Trieger, Psy.D.
Licensed Clinical Psychologist

Melissa Fisher Paoni, Ph.D.
Licensed Clinical Psychologist

Lori K. McKenzie, Psy.D.
Licensed Clinical Psychologist

Bill McKenzie, LCPC
Licensed Clinical Professional Counselor

Springfield Psychological Center, LLC

Greg Irwin, LCPC
Licensed Clinical Professional Counselor

Jeanette Hoelzer, LCPC
Licensed Clinical Professional Counselor

Bethany Bilyeu, Psy.D.
Licensed Clinical Professional Counselor

Kelsie Tobias, LCSW
Licensed Clinical Social Worker

Financial Agreement for Psychological Testing

Fees:

90791 – New Patient Diagnostic Evaluation	$200.00
96136 – Psychological Testing Primary Code – first 30 minutes (includes test administration and scoring)	$90.00 – first 30 minutes
96137 – Psychological Testing Secondary Code – 31 minutes and over (includes test administration and scoring)	$90.00 - each additional 30 minutes of testing
96130 – Clinical Decision Making, Record Review, Test Selection, Report Writing, and Parent Feedback – Primary Code - first 60 minutes	$170.00 - first hour
96131 – Clinical Decision Making, Record Review, Test Selection, Report Writing, and Parent Feedback – Secondary Code – 61 minutes and over	$170.00 – each additional hour

Agreement:

- I request that Springfield Psychological Center, LLC, provide services to me or my child and agree to pay the fees in accordance with the fee schedule listed above.
- I agree that this financial relationship with Springfield Psychological Center, LLC will continue as long as the practice provides services to me or my child or until I inform the practice that I wish to end the assessment.
- I agree to allow Springfield Psychological Center, LLC to submit the testing to my insurance, and I will be responsible for any amount the insurance deems my responsibility.
- I agree to pay any fees that accumulate during the assessment, if I choose to not finish out the testing. I agree to pay full price of the testing time rendered, and understand that any noncompleted testing will not be submitted to insurance.
- I agree that after the initial intake, testing appointments will not be scheduled until I select a payment option below.

Insurance:

- I give permission to Springfield Psychological Center, LLC to bill my insurance for services rendered, and I will be responsible for any balance once processed through insurance.
- I understand that some insurances do not cover certain diagnoses, and I will be financially responsible for any amount insurance deems my responsibility. For example, learning disabilities are not covered by some insurance plans.

Payment:

- I agree to be financially responsible for any balance incurred, and marked (with my initials) the preferred payment option:

1) A $500.00 retainer that will apply to psychological services provided; patient will pay any balance over the $500.00 retainer. _____
2) Set up a credit card to be processed once a month, after testing services have been completed and insurance determined the patient responsibility amount. I agree to fill out the credit card form today with a guarantee of future monthly payments of my choice. _____

My signature below shows that I, _____, understand and agree with all these statements.

_____ _____

Responsible Party (Patient or Parent of Child Patient) Date