Elicia M. Seay, Ph.D.

Licensed Clinical Psychologist

5250 Cherokee Ave., Suite 410
Alexandria, VA 22312

Phone (703) 354-1144
Fax (703) 831-8752

CONSENT & PAYMENT AGREEMENT
ELICIA SEAY, PH.D., LLC

5250 Cherokee Avenue, Suite 410, Alexandria, VA 22312
(703) 354-1144 / (703) 831-8752 (fax)

PAYMENT IS REQUIRED AT THE TIME SERVICE IS RENDERED

Fees & Payments: By signing below, you are confirming that you understand that Elicia Seay, Ph.D., LLC will submit your claims to your insurance company for payment, and subsequently issue patient statements to you regarding any remaining balance due.

Further, you understand that it is your responsibility to provide Elicia Seay, Ph.D.,LLC with appropriate and current insurance information and updates to ensure efficient claims billing and payment.

Furthermore, you understand that it is your responsibility to have obtained all necessary referrals and authorizations required prior to treatment. In the alternative, you understand that if you have not obtained these necessary referrals or authorization, you may agree to accept complete responsibility for the entire balance of fees for treatment in the event of an insurance company denial for lack of referral.

You understand that you will be responsible for paying your co-payments, deductible, and any fees relating to services rendered that are not fully (or at all) covered by your insurance company. You understand that if your insurance requires a co-pay, the co-payment is to be made at the time that services are rendered. If you are not using insurance, you will be expected to pay for each session at the time that it is held. In circumstances involving unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

______________________________ (patient initials)

Patient Discharge / Collections Fees: In the event of failure to pay for services rendered, you understand that you may be discharged from the services until such time as your account is paid. Additionally, you understand that you may be referred to a collections agency for non-payment of fees due for services rendered. You understand that you will be responsible for a 30% collection fee, all agency and attorney fees and costs associated with the collection process (such as court costs), and that these fees and costs will be added to your account balance. You understand that you will be responsible for paying the entire amount of your balance due ***in addition to*** the collection agency fee. Further, you understand that your PHI will necessarily be revealed in these efforts to collect payment of monies owed.

______________________________ (patient initials)

Returned Check Fee: A $35.00 fee will be assessed for each returned check.

______________________________ (patient initials)

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Professional Fees: My hourly fee is $170.00 for individual therapy, $200.00 for couple's therapy. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will pro-rate the hourly fee for periods of less than one hour. Such other services include report writing, telephone conversations lasting 15 minutes or longer, consulting with other professionals (with your agreement and permission), preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $280.00 per hour (with a minimum engagement of three (3) hours) for preparation for and attendance at any legal proceeding.

_________________________ (patient initials)

Meetings/Missed Appointments: Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of the cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. All missed appointments which were canceled fewer than 24 hours prior to the scheduled appointment time will be billed at $75.00 fee. I do not prorate or discount for missed sessions. If you do not show up for your scheduled appointment, you will be responsible for the full cost of the session ($170.00). It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

_________________________ (patient initials)

Assignment of Benefits: By initialing below, you hereby authorize payment of all medical insurance benefits which are payable under the terms of your insurance policy to be paid directly to Elicia Seay, Ph.D.,LLC for services rendered. You further authorize the release of any information needed for the purposes of treatment, payment and health care operations, including the processing these insurance claims.

_________________________ (patient initials)

Your signature below indicates that you have read this entire agreement and agree to its terms.

Patient/Guardian Signature: ____ **Date:** ____/____/______