

Payment Agreement for Psychological Evaluation

Pricing and Cost

The total cost for this evaluation is estimated to be _____ which includes to whatever extent necessary or applicable:

- Administration of psychological tests to assess:
 - Intellectual functioning
 - Achievement potential
 - Emotional, personality and social functioning
 - Perceptual difficulties
 - Assessment of learning disabilities and/or related developmental delays
- Clinical interviews and collateral contacts with parents, school, physician(s), and other relevant parties as needed or indicated (a separate release of information form will need to be signed by you if necessary)
- Review of academic records and/or previous testing reports
- Scoring and interpretation of test results
- Report writing time
- Providing a feedback session upon completion of testing to review the results and provide recommendations based on the findings of the evaluation
- Other: _____

Payment Agreement

A credit card number is required prior to the evaluation. Your card will not be charged for payment unless specifically authorized by you. However, we reserve the right to charge your credit/debit card for unpaid balances, violations of this payment agreement, returned checks and any associated bank fees.

A deposit of no less than **50%** _____ will be paid at the time of the initial appointment by cash, check or credit/debit card (Visa, MasterCard, or Discover). The remaining balance of will be paid upon completion of the testing, and prior to receiving a copy of the testing report. Additional fees may be added at a rate of \$150 per hour if testing takes much longer than expected, or if we both agree that additional testing would be beneficial. Typically this is not necessary, however, in either case you will be notified about this in advance before your account is charged. Additional fees may apply if an expedited report for this evaluation is required outside of a reasonably expected time frame (2-3 weeks after all testing is completed).

In the event that your account becomes past due (60 days or more) and we have not made other arrangements for payment, then we reserve the right to charge the account indicated on page 2 of this agreement for the unpaid balance or use a collection agency until your account is reconciled.

Non-payment:

Please note that your account will be referred to IC System, a national collection agency if your account becomes 60 days past due. Please be aware that if your account continues to be unpaid IC System is authorized to report all outstanding debts to the four major national credit agencies and may pursue litigation to recover your debt (other legal fees may apply).

Additional Cost of Collection Services:

Invoices shall be deemed to be accepted by you unless we are notified in writing within 14 days of the invoice being issued that you dispute the amount of the invoice. In the event of non-payment, we may in addition to the invoice amount charge:

- i. Interest on any outstanding amounts from the date due calculated at the statutory penalty rate of 6%
- ii. Legal and debt collection fees incurred by the practice in relation to the recovery of outstanding amounts.

Authorization

I authorize Psychology Associates of Chester County, Inc. to charge the credit/ debit card below for the following:

- Do not charge card at this time, however, I understand that my account may be charged for the reasons stated above (Card information and signature still required)
- This visit only \$ _____
- Balance due on account not to exceed \$ _____
- Recurring charges of \$ _____ to be charged every _____
(frequency)
From _____ to _____
(date) (date)

Check One:

- Visa®
- MasterCard®
- Discover Card®

Name of person being evaluated: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ CVV: _____ Exp. Date: _____

Cardholder Signature: _____ **Date:** _____

If paying by check, please make checks payable to: **Psychology Associates of Chester County, Inc.**

I have carefully read all the terms of the above guidelines and agree to abide by its guidelines. I have had an opportunity to ask questions acknowledge that I am entitled to receive a copy of this agreement.

Signature of Responsible Party

Date

Relationship to person being evaluated