

Brenda K. O'Reilly, Ph.D., Professional LLC  
Licensed Clinical Psychologist  
Board Certified Professional Counselor

### **CLIENT RESPONSIBILITIES AND FEES**

Usual and Customary Fees (Note: Discounted fees are applied in accordance with in-network health insurance allowed rates)

Intake Evaluation (60 minutes) - \$200  
Psychotherapy 20 - 30 minutes - \$110  
Psychotherapy 40 - 45 minutes - \$140  
Psychotherapy 55 minutes - \$170

#### Health Insurance

Your health insurance plan should provide coverage for outpatient psychotherapy as an individual mental health/behavioral health benefit; the best benefit for patients involves treatment by an in-network provider. It is your responsibility to understand your copayment/coinsurance and/or deductible and whether any preauthorization of services is required. Because these services are rendered to you, and not your insurance company, you will remain financially responsible for payment of all services. At or before your first visit, please submit a copy, front and back, of your insurance card in order to facilitate our filing of claims. Our office will verify your benefits with your insurance plan.

#### Payment for Services

ALL PROFESSIONAL CHARGES ARE DUE AND PAYABLE AT THE TIME OF TREATMENT. Our office accepts checks and credit/debit cards. If you are certain that your health insurance pays a specific amount, you may pay only your copayment, coinsurance, or deductible up front. This office will file insurance claims for you as a courtesy. It is the client's responsibility to discuss any difficulty with this policy in advance.

#### Good Faith Estimate

If you are not utilizing health insurance, you have the right to receive a "good faith estimate" of the expected cost of psychotherapy services. The expected costs are the Usual and Customary Fees listed above. Dr. O'Reilly will collaborate with you throughout your treatment to determine how many sessions you may need to receive the greatest benefit based on your presenting concerns. The total cost of services will depend upon the number and length of psychotherapy sessions you attend, as well as your individual needs and circumstances. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

#### Missed Appointment/Late Cancellation Fee

Cancellation of a session without 24 hours advance notice means that someone else who urgently needs to be seen cannot be scheduled. Therefore, unless there is an emergency/unforeseen circumstances (e.g., illness, auto breakdown, snowstorm) a cancellation with less than 24 hours notice, or not showing up for a scheduled appointment, will be charged a \$50 fee which cannot be billed to insurance. Sessions will begin no later than 15 minutes after the scheduled time or it will be considered a missed appointment. Three missed appointments/late cancellations (not due to emergency/unforeseen circumstances) will be considered a termination of services. Our office does not provide reminders of scheduled appointments.

#### Correspondence/Copying Fee

A routine charge of \$50 will be made for requested correspondence such as treatment summaries or letters and documents that require a review of the treatment file; this charge also applies for copying/ mailing medical records.

#### Video Sessions, Telephone Consultation, and Emergency Services Fees

Video sessions, telephone consultations, and crisis interventions are billed the same as the in-person rate.

#### Returned Check Fee

A routine charge of \$25 will be made for any check returned for insufficient funds or any other reason.

#### Legal Proceeding Fees

If Dr. O'Reilly is subpoenaed or otherwise required to participate in a legal proceeding as a result of providing professional services to you, you will be responsible for paying the full professional fee of \$250 per hour for all time expended on preparation, transportation, and testimony.

#### **CLIENT FINANCIAL AGREEMENT**

I have read and understand the client responsibilities and financial policies indicated above. I accept responsibility for the payment of all charges under the above terms. I understand that if my account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, then legal means may be used to secure the payment. This may involve utilizing a collection agency or going through small claims court. I hereby authorize the provider to release any information required to process claims for services or to obtain payment for services. I also assign insurance benefit payments directly to Dr. O'Reilly.

Signature \_\_\_\_\_ Date \_\_\_\_\_