AZITA AFSHAR, PSY.D.

PROVIDER AND PATIENT AGREEMENT FORM

Professional Fees Are Due At The Time Services Are Rendered.

Fees for services are based on a 55-60-minutes psychotherapy hour. I am an in-network provider for BCBS PPO plans only. If you are using your in-network insurance plan, any applicable copays will be due at the time of each session. If you have a deducible or co-insurance portion on your in-network plan, then that will be billed to you, in accordance with the contracted amount on your plan, after your claim has been processed. For your own financial planning, please also be sure to verify any out-of-pocket obligations. You must sign The Authorization to Release to Insurance Form in order for me to be able to submit your in-network claims to BCBS PPO.

I do not submit claims for out-of-network coverage, and the below fees apply for sessions. If you have out-of-network benefits and wish to seek reimbursement from your insurance company, a monthly statement, indicating sessions paid, can be provided to you at the end of each month. If you wish to submit more regularly, we can certainly make those arrangements.

If you wish to not use insurance and/or pay for your sessions out-of-pocket then the below fees apply. Payment is due at the time of each session unless other arrangement have been made between you and me.

Diagnostic Evaluation	**$275**
Individual/Interactive Psychotherapy (55-60min)	**$200**
Couples Therapy (60-min)	**$250-$300 **Please note that this service is not covered by health insurance plans.**
Customized Psychotherapy (out-of-pocket). *This service is for individuals not using an insurance plan and who may benefit from customized sessions that can better fit their needs (e.g., longer or shorter sessions, support or guidance with challenging tasks, etc).	**Please note that customized rates may vary. Please inquire with Dr. Afshar.**
Telehealth (55-60min)	**$200**
Returned check fee and/or late fee	**$30 (per month for late fee and each returned check).**

Cancellation Policy

All cancelations require a twenty-four (24) hour notice. When you make an appointment, you are reserving professional time set aside specifically for you. Please be aware that late cancelations or missed appointments mean this time cannot be offered to another patient, and **you will be charged the full session fee**. Please note that insurance companies will not reimburse cancellation charges. Your time is equally as valuable, so if I have to cancel or miss an appointment without 24 hour notice, you will be credited one cancelled session. In the event of an emergency, cancellation/missed fees will not apply.

Late Sessions

Typically, sessions that start more than 8-minutes past their scheduled time cannot be billed to insurance for that session limit. Insurance companies do not reimburse for unused time; hence, you will be charged the full session fee (out-of-pocket) for sessions that start more than 8-minutes past their scheduled time. In the event of an emergency, sessions can be rescheduled to allot for the full session time.

Confidentiality and Limits to Confidentiality:

Information you share is kept strictly confidential and will not be disclosed without your written consent. I will use confidential information for the purpose of treatment, payment, and operations. Confidentiality is **not guaranteed** in life-threatening situations involving yourself or others, or in situations in which children are at risk, such as abuse or neglect. Please refer to the document(s) titled "HIPPAA ILLINOIS NOTICE FORM" for more detailed information regarding limits of confidentiality.

Consent for Treatment: By signing below, I agree to receive mental health services from Azita Afshar, Psy.D. I understand I can stop treatment at any time.

Acknowledgement of Receipt of HIPPA Illinois Notice Form: By signing below, I acknowledge I received the HIPPA Illinois Notice Form outlining privacy regulations relevant to my care.

I, _____, have read, understand, and agree to the above stated policies. I agree that payment is due at the time of the service and that all past-due accounts will accrue a late fee of $30 per month until paid. If collection through collection agencies or other legal proceedings becomes necessary, I will be obligated to pay reasonable attorney's fees and costs incurred in collection. I agree that my protected health information may be disclosed for the purposes of treatment, payment, and healthcare services. I consent to treatment, have read and understand the HIPAA Notice of Policy and Practices in full, and have had sufficient opportunity to ask questions/seek clarification.

Patient Signature:_____ Date:_____