PROVIDER AND PATIENT AGREEMENT FORM

Professional Fees Are Due At The Time Services Are Rendered.

Fees for services are based on a 60-minute psychotherapy hour. Additional time will be billed accordingly. Payment is due at the time of service and can be made in cash or check. If you have out-of-network benefits and wish to seek reimbursement from your insurance company, a monthly statement, indicating sessions paid, will be provided to you at the end of each month. If you wish to submit more regularly, we can certainly make those arrangements. You must sign a Release to submit to insurance companies.

90791	Diagnostic Evaluation	$275
90837	Individual/Interactive Psychotherapy (60-min)	$190
90837	Couples Therapy (60-75 min)	$200-$250
------	Returned check fee and/or late fee	$30 (per month for late fee and each returned check).
------	Telehealth	$190 *please be advised that insurance companies do not typically reimburse for Telehealth unless your plan carries this provision, or under special circumstances (i.e, covid-19 pandemic).

CPT codes listed above are the most common. Other CPT codes may be used depending on treatment needs.

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:_____