**Peter Tolisano, Psy.D., LLC**

68 South Main Street, Suite 200

West Hartford, CT 06107

***Form B***

***Payment Agreement***

1. **By signing this agreement, you are confirming that you are responsible for all therapy fees regardless of whether or not they are covered by an insurance carrier. *For example, the client is responsible for the session fee if the deductible is not met.***
2. **Full payment or copayment is required at the time of service in the form of cash, personal check, or cashier’s check at the agreed upon rate.**
3. Regarding insurances, it is the client’s responsibility to:
* confirm with the insurance company coverage under their specific plan;
* provide current insurance information to ensure billing and payment;
* obtain all the necessary authorizations required for treatment.
* Notify of any changes to their insurance coverage.
* Do not assume that your insurance will be automatically be covered or that a lower rate will be accepted.
1. Peter Tolisano, Psy.D. reserves the right to discuss an adjustment in session fees as needed for self-pay cases.
2. Additional fees will occur if personal checks are returned because of insufficient funds.
3. For unpaid accounts, Peter Tolisano, Psy.D., LLC may pursue legal means to secure payment, such as hiring a collection agency or using small claims court. Clients incur the costs of legal action if it becomes necessary.
4. Peter Tolisano, Psy.D. may request compensation for time spent performing other professional services, such as preparation of reports related to treatment or participation in legal proceedings.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***My signature indicates that I have fully read, understand, and agree with this policy.***