

Tracy R. Zemansky, Ph.D.
COURAGE TO CHANGE, INC.
Clinical Psychology – Psychological Assessment – Psychotherapy - Interventions

Dear Client (and/or Parent/Guardian),

Attached please find the **Consent and Financial Responsibility Form** for the Psychological Evaluation. As discussed, my estimate for a typical Psychological Assessment or a Collaborative/Therapeutic Assessment at this time is \$ _____, though this may be higher if more testing is required, if significant time is needed to review prior treatment records, if we meet at a location other than my office, and depending on how much time is needed for telephone consultation with prior treatment providers and/or other collateral contacts.

I will have a final estimate of costs once we meet, and after I get any documents or additional information from current or past treatment providers. When scheduling a typical **Psychological Assessment**, we will generally meet once for a clinical interview and testing (usually between 4-6 hours total), then meet again for an hour to discuss the results after they are completed, which takes between two to four weeks.

When doing a **Collaborative/Therapeutic Assessment**, I expect to have an initial meeting (which may include your therapist, if you are currently working with one), at least two 3-4-hour testing sessions, and one or more additional sessions to review and discuss testing results. I generally schedule those appointments after our first meeting so that we both know the dates and times in advance. I will send a final letter to you within approximately 4-6 weeks after our last meeting. I will also make myself available to speak with you, or any treatment providers on the phone after the assessment is done if clarification is needed. If you choose, I invite you to have a follow-up meeting with me around six months after our final Summary/Discussion session to review the process. This session is included in the fee. If you are in therapy and would like to invite your therapist to participate in some of the Collaborative/Therapeutic Assessment, we can discuss the best way to do this so we can all work together as a team on your behalf.

The full amount of the estimated fee and the signed Consent and Financial Responsibility Form are due ten days prior to my first meeting with the client. The Consent Form can be faxed or emailed back to me. I will provide my bank information if needed for electronic transmission of funds, or you can mail a check (made out to **Courage to Change, Inc.**) for the estimated amount to my office. Other payment arrangements may be possible but must be discussed in advance. If an additional amount is owed, it will be billed as soon as I am aware of the cost; those fees must be paid prior to my writing the report. Please contact me (email is fine), or my Office Administrator, if you are transferring money electronically.

If you have any further questions, please do not hesitate to contact me. I look forward to working with you.

Respectfully,

Tracy R. Zemansky, Ph.D.

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FINANCIAL RESPONSIBILITY AGREEMENT

The following schedule summarizes my fees for service as of September 2014:

Intake Appointment: \$500/session (90 minute session)
Individual Therapy: \$250/session (45 minute session)
Couple/Family Therapy: \$330/session (60 minute session)
Psychological Testing: \$330/hour (includes clinical interview, test administration, test interpretation and report writing, summary/discussion session)
Group Therapy: \$80/session

Sliding Scale Fees may be available, but are dependent on specific circumstances.

Under the terms of this Agreement, the patient or patient's legal guardian is responsible for full payment for services.

Even if you plan to use insurance benefits, **full payment is due at the time of service.** I will provide a Super Bill that you can submit directly to your insurance company; they will send any payments to you.

Cancelled or missed appointments with less than 48 hours notice are billed at the hourly fee and must be paid in full by the next session. This may not apply to appointments that are cancelled for illness or emergency, depending on particular circumstances.

Psychological testing and assessment fees are due in full prior to beginning the testing unless we specifically discuss other arrangements and agree to these in writing. Generally the full estimated testing fee is due at least ten days before our first meeting; any additional fees are due prior to my writing the report. I will usually have an accurate estimate of fees after our first meeting; however, sometimes this may change if we determine additional testing, review of records, or telephone consultations with prior treatment providers or other collateral contacts will be necessary.

It is agreed and understood that any charges incurred are the sole responsibility of the patient and/or the responsible party signed below. Bounced checks are subject to a \$35 service charge. Any past due balance older than 30 days will be subject to a late charge of 2% per month. It is agreed and understood that if this obligation should become delinquent that you, the patient or responsible party, agree to pay collection costs, attorney's fees, and any costs associated with placing your account with a collection agency and/or an attorney for litigation.

I have read the policy statement and agree to these policies. I hereby guarantee payment of charges for psychological services and understand that I am fully responsible for payment.

Name of Patient: _____

Name of Person with Financial Responsibility: _____

Signature of Person with Financial Responsibility

Date/Time

Psychologist Signature

Date/Time