Gerald W. Greenfield, Ph.D.

Licensed Psychologist

6409 Odana Rd.
Madison, WI 53719
(608) 271-8799

Individual Psychotherapy
Marital and Couples Therapy
Evaluations

Treatment and Financial Agreement

FEES AND ACCOUNT INFORMATION:

Fees for psychotherapy services: Intake/first session, 45-50 minutes: $200; individual therapy, approximately 45 minutes, $140; marital/couples therapy, approximately 45 minutes, $150. A $10 administrative discount is offered for full payment at the time of the session by cash or check, when no billing or statements are required. Credit cards (Visa/MC) are accepted, in which case the discount is not offered. Fees for other services (e.g., testing, legal consultation) will be set prior to provision of the service. Fees may be discounted based on financial need; any such discounting must be established in advance.

Responsibility for payment: YOU ARE RESPONSIBLE FOR THE COSTS OF ALL SERVICES PROVIDED BY DR. GREENFIELD. Insurance claims will be submitted to your insurance carrier, as a service to you (see "Processing claims," below). However, you are ultimately responsible for payment of all fees, including any not paid by your insurance carrier for any reason, including but not limited to: lack of prior authorization; deductible and co-pay requirements; exceeding of benefit limits; and any services not covered by your policy (e.g., services for uncovered diagnoses; correspondence or report-writing; telephone therapy). You are expected to find out all necessary information about your insurance coverage, including authorization/referral requirements if any, covered services, and coverage limits. Please discuss any questions with Dr. Greenfield.

Payment and Statements: I typically collect copays and deductibles at the time of the session. Statements are typically issued when there are unanticipated balances due, or upon request.

Processing claims: By signing this agreement, you authorize Dr. Greenfield and his support staff to submit claims to your insurance carrier(s), and to release to them any information necessary to process and collect these claims. (See Notice of Privacy Practices.) By signing this agreement, you also authorize your insurance carrier(s) to make payment directly to Dr. Greenfield. Any such payments will be credited directly to your account. If you are using insurance, it is important that you keep track of service costs, insurance benefits, and any insurance limits.

Balances: Any fees not paid at the time of the session are due within 30 days of service unless other arrangements have been agreed upon. Right is reserved to charge interest (1½% per month) on unpaid accounts that are over 60 days old. The maximum allowable balance on accounts is $700. If your account balance reaches $700 (e.g., due to delay in insurance processing of claims), the right is reserved to require payment in full for past charges that are 60 days old and for further services at the time such services are provided. (Any subsequent overpayment – e.g., if insurance later pays for services – will be credited promptly to your account.)

Dr. Greenfield reserves the right to seek legal means to secure reimbursement of delinquent accounts. (See Notice of Privacy Practices.)

(continued)

CANCELLED/MISSED APPOINTMENTS:

When it is necessary to cancel or change a scheduled appointment, you are required to do so at least 24 "business hours" in advance (i.e., by 10 A.M. Thursday for a 10 A.M. Friday appointment, but by 10 A.M. Friday for a 10 A.M. Monday appointment). YOU ARE RESPONSIBLE FOR FULL FEES (NOT JUST COPAYS) FOR APPOINTMENTS THAT ARE MISSED OR CANCELLED LESS THAN 24 (BUSINESS) HOURS IN ADVANCE. INSURANCE DOES NOT REIMBURSE FOR CANCELLED OR MISSED APPOINTMENTS.

CONFIDENTIALITY:

All records and communication between you and Dr. Greenfield are confidential unless written authorization is provided by you, except as provided in Dr. Greenfield's Notice of Privacy Practices, and/or as authorized here:

(i) Do you authorize Dr. Greenfield to notify the person who referred you that you followed through with the referral?
Yes___ No___ If yes, name and phone # of the referring person: _____

(ii) If the person who referred you was a health care provider, do you authorize Dr. Greenfield and the health care provider to share clinical information about you? Yes___ No___

(iii) Do you authorize Dr. Greenfield and your physician to share clinical information about you?

Yes___ No___ If yes, name and phone number of physician: _____

If you are having Dr. Greenfield submit claims to insurance, he cannot be responsible for what the insurance company does with information he provides after he has provided it. It is Dr. Greenfield's impression that such information may impact on a client's subsequent efforts to obtain various types of insurance. It is, unfortunately, one of the uncertain potential costs for utilizing your insurance to pay for psychotherapy (as well as other healthcare) services. Please feel free to talk to Dr. Greenfield about these or any other concerns you may have.

Agreement: I have read, understand, and agree to the statement of fees, policies, and provisions described above.

Client Signature: _____ Date: _____

Additional Client, or
Financially Responsible Person: _____ Date: _____

Provider Signature: _____ Date: _____

If you found me on the internet, would you mind telling me how you found me?

What search engine did you use? _____ What terms did you search? _____

What website(s) did you use? (i) www.greenfieldtherapy.com ___ (ii) Psychology Today ___

(iii) GoodTherapy ___ (iv) Other ___ What other site? _____

If you did not find me on the internet, how did you find me? _____ Thanks!