**Binding Payment Policies**

We are dedicated to providing exceptional psychological care—we are not a lending institution or collection service.

**We accept in-network discounted fee amounts from insurance plans**. However, insurance coverage information in advance about estimated costs provided by online tools or telephone customer service representatives about insurance coverage is not reliable; their disclaimers always say “**final insurance coverage determinations are governed by your plan benefit documents” to which we have no access.** We stand behind our billing services and are happy to answer questions about charges made to your account. You may contact us in writing at pennpsychology@pennpsyc.com with billing questions.

* A valid bank credit, debit or HSA card is required to keep on file **prior** to receiving services.
* Patients are required to provide the most correct and updated information regarding insurance as soon as it becomes available, so that insurance can be billed correctly.
* Copayments are due on the day of service. For all types of visits the card on file will be charged immediately for copays or deductibles. You will be refunded promptly should any overpayment occur after your insurance company processes the claims.
* Patients are responsible for payment of **copays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan** and are due after insurance(s) have responded. The card on file will be billed immediately by the clinician or billing department.
* If payment is not received in a timely manner, the account will be forwarded to Collections.

**Broken Appointment Policy**

For both Penn Psychological Associates and the Neurobehavioral Assessment Center we require **24 hours’ notice** to cancel or reschedule any kind of appointment in our office or via telehealth. Without this notice, we cannot provide care to another patient who may need treatment. A $75 charge will be processed for broken appointments; those who repeat this may be dismissed from the practice.

**By signing this, I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Print Name) understand and acknowledge PCA and NBHSJ’s Health Payment Policies.**

**Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**