Family Therapy Clinic

8480 Bluebonnet Blvd, Suite A
Baton Rouge, LA 70810-2879
Tel: (225) 292-0155 Fax: (225) 292-0157

Office Policies and Procedures

Office Hours & Contact:

- The office is open Monday through Friday from 9:00 am to 5:00 pm, except during regularly scheduled holidays.
- Most phone calls and email contacts are responded to within the same day, but due to limited staffing responses may sometimes be delayed. For more immediate needs, patients are encouraged to use of the electronic messaging system via our online patient portal, or in case of emergencies call 911.

Services: *(*most common services)*

Psychological
*Initial Diagnostic Visit *(90 mins)* - $350
*Routine Counseling *(45 mins)* - $180
*Medication Management – Moderate Complexity *(15 mins)* - $90
Brief Counseling *(15-20 mins)* - $75
Medication Management – High Complexity *(30 mins)* - $150

Social Work
*Initial Diagnostic Visit *(60 mins)* - $150
*Routine Counseling *(60 mins)* - $120
Brief Counseling *(30 mins)* - $55

Evaluations
General Psychological Evaluation - $990
Mandated Evaluation *(fitness-for-duty, court-ordered)* - $1140
Pre-Surgical Evaluation *(bariatric, spinal cord stimulator)* - $990
Pre-Adoption Evaluation - $1740
ADHD Evaluation *(ages 15 & up)* - $1290
IQ Testing *(ages 15 & up)* - $490
Achievement Testing *(ages 15 & up)* - $490
Career Interest Screening - $75
Other Specific Psychological Testing - $225/hr

Forensics
Court-Related Consultation - $350/hr
Legal Deposition - $350/hr *(paid in advance)*
Trial Testimony - $350/hr
Court-Related Travel - $250/hr
Legal Case Preparation & Review - $250/hr

Insurance & Financial Considerations:

- **Late Cancel/Missed Appointment** - Appointments canceled with less than a 24-hour notice will be subject to a Late Cancel Fee of $50 *(exceptions considered for significant illness or emergency situations)*. Missed appointments will be subject to a No Show Fee of $75 *(no exceptions)*
- **Insurance Pre-Authorization** - We attempt to verify insurance benefits prior to your first visit. However, it is strongly recommended that you also call your insurance company prior to your first visit to obtain pre-authorization and clarification of benefits. Note that pre-authorization does not necessarily represent a guarantee of payment from the insurance company.
- **Payment Responsibility** - You will be responsible for payment of all charges incurred at the time of service, which will typically be your co-pay/co-insurance amount if using insurance. If you have not met your deductible your responsibility will be the Full Insurance Allowable Charge, or the Full Charge *(listed above)* if not using insurance.
- **Delinquent Payments** - If you are unable to make full payment of your account balance, you should discuss payment options with the office manager & clinician providing services. Failure to pay your account balance or any agreed to payment plan may subject your account to late fees and possible collections procedures.

- **Credit Card on File** - Due to changing co-pays, unmet deductibles, uncovered services, and missed appointment fees, account balances can balloon very quickly. In order to streamline billing/payments and avoid large balances we maintain a Credit Card on File policy.
    - After verification of insurance benefits, we will use your card only for the amount determined to be "patient responsibility". You may choose to use an alternative form of payment (e.g., cash, personal or cashier's check), but full payment will be required at the time of service.
    - Your card may be used for deductible & co-insurance amounts, any non-covered services, missed or inaccurate co-payments, and missed-appointment/late-cancel fees.
    - If your card on file changes, we require that you notify us immediately. If we run the card on file and it is denied for any reason, we reserve the right to charge an additional $25 fee.
    - If there are any questions or disagreements about charges to your card, we will investigate the matter as quickly as possible. In the event of an overcharge, we will refund the amount to the same card in a timely manner.

Please complete the information below:

Cardholder's Name: _____
Relationship to Patient: _____
Billing Address: _____
_____
Card Type: □ Visa □ MasterCard □ Discover □ AmEx □ Other
Card Number: _____
Expiration Date: _____
CCV#: _____
Cardholder Signature: _____
Date: _____

Financial Agreement:

The Responsible Party for this account is that person/s responsible for the patient's financial liability. An adult patient is generally considered to be the Responsible Party for his/her account unless otherwise stipulated. The Responsible Party for this account should review the conditions set forth below then sign and date.

I understand and agree to the following:

- Payment is due at the time of service
- I accept full responsibility for the complete payment of this account
- I have read and will abide by the Insurance & Financial Considerations listed above

_____
Patient Printed Name

_____
Responsible Party Printed Name *(if different from patient)*

_____ _____
Responsible Party Signature Date