NANCY IREY HOLMES, PSY D

Licensed Psychologist

Portland: (503) 235-2466 Redmond: (541) 330-4428

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FEE AGREEMENT AND INSURANCE INFORMATION

Fees: The standard service charge is $225 for an initial consultation, $150 per 50 minute office appointment and $225 per 90 minute office appointment. Longer sessions are prorated at the same hourly fee.

Please *check* one of the following:

_____ **1) SELF-PAY:** I agree to pay in full at the time of service.*

*Exception: If we have agreed on this, the fee for treatment will be $_______ per session. I agree to pay at a minimum rate of $_______ per week/month until the balance is paid in full.

_____ **2) INSURANCE:** The following information must be completed and verified. It is important for me to estimate what your insurance, if any, will cover and for what length of time. This may affect our treatment goals and the frequency of treatment which must be appropriate to your needs.

Name of Client:_______________________________________ Client's Date of Birth:__________________

Name of Person Insured: __________________________________ Insured's Date of Birth: ____________

Client's Relationship to Insured: ________________________________

Insured's Mailing Address: ____

Address City, State & Zip

Insured's Home Phone: _____________________________ Work Phone:____________________________

Insured's Employer: __________________________________ Effective Date of Coverage: ______________

Primary Insurance Co.: ____ Phone: ______________________

Is there another insurance company who manages your mental health claims? Yes ❑ No ❑

If so, please provide name & phone number:____

Address to Send Mental Health Claims: ____

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Subscriber #: ____________________________________ Group #: __________________________________

Policy # (if any): ______________________________ Visits/calendar year or other time frame: __________

Number of Mental Health Visits in this Time Frame: _____________ Annual Deductible: $___________

Deductible Remaining: Yes ❑ No ❑ Co-Pay required per visit? Yes ❑ No ❑ Co-Pay Amt. $ _________

Is my fee within your insurance company's range?* Yes ❑ No ❑ Specify amount covered: $ _________

* Sometimes my fee exceeds the insurance company's allowance and in most cases you will need to make up the difference.

If necessary, have you received pre-authorization? Yes ❑ No ❑ Pre-Authorization #: ____________

Total Outpatient Mental Health Benefit: $___________ Specify Details: ___________________________

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Do you expect your health benefits for change in the near future? Yes ❑ No ❑ If so, please explain:

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In many cases, after the initial consultation I will bill directly to your primary insurance company for the portion of the bill they will cover. However, it is your responsibility to bill any secondary insurance you may have. Because of the delay in reimbursement, in most circumstances I request that you pay directly for costs not covered by your primary insurance.

Secondary Insurance Co.:_______________________________________ Phone:____________________

Insured's Name:___________________________________ Subscriber/Policy #:_____________________

Group #:_________________ Address:____

I have read, understand and agree to the terms of this form. By signing this form I authorize the use of the signature(s) below on all insurance submissions and also authorize the payment of medical benefits to Nancy Irey Holmes.

____ _____________________________

Client Signature **Date**

____ _____________________________

Client Signature **Date**

____ _____________________________

Parent or Guardian Signature if Minor Child **Date**