Sarah Ray, Psy.D., QME
Advanced Health Care

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Payment Policies

1. We accept cash, check or credit card. Patients will be charged an appropriate fee, based on our fee schedule, for any professional time spent in responding to written information requests and lengthy telephone consultations. Any service greater than 15 minutes, including phone calls and forms, will result in a charge.
2. Fees or co-payments are **due at the time of the appointment**. You may write a check beforehand if you want to save time during the session. We accept all forms of payment.
3. Insurance: If you expect another payer to be paying for part of your session, it is your responsibility to ensure that you are covered by that payer. **You will be responsible for all charges that the payer does not cover.**
4. If you are using insurance on an out-of-network basis, you are responsible to pay upfront and you will be reimbursed by your insurance company at their negotiated rate.
5. Please understand that your insurance company may be using a carve-out carrier for their mental health coverage. In some circumstances, even if your insurer informs you or our company that the services are covered, there is a chance that your actual benefits may vary upon receipt of the first Explanation of Benefits to our office. **Again, you will be responsible for all charges that the payer does not cover, even if your coverage ends up being different than originally expected.**

Cancellation and No-Show Policy:

If you need to cancel, please call at least 24 hours in advance.

Cancellation fees are as follows:

1. 24 hours or more in advance: No fee
2. Less than 24 hours in advance: $100.00 fee (or the or the allowable amount paid by your insurer)

No-Shows: If you do not show up for your appointment, and did not call prior to 24 hours before your appointment, there is a $100.00 no-show fee or the allowable amount paid by your insurer. **Insurance does not cover no-show fees, and you will be responsible for this fee even if you are using insurance.**

My signature below shows that I understand and agree to comply with the late cancellation/no show policy.

Signature of Patient _____ Date _____

Print Name of Patient _____