FINANCIAL POLICY FOR:

SUSAN COHN & ASSOCIATES, PC

We will bill charges to your insurance company using one or more of the following procedure codes based on the specific services rendered during the session (Additional procedure codes may be included if warranted at time of service):

92506	evaluation
92506 & 92507 – 59	Evaluation & Therapy Diagnostics
92507	therapy

It is your responsibility to know your co-payment or co-insurance obligation and if you have an annual deductible liability left to satisfy. We call your insurance as a courtesy to you to verify coverage and/or benefit limits, however this is not a guarantee of coverage. It is your responsibility to verify with your plan what, if any, requirements are needed for coverage prior to your initial evaluation or first visit date. You will be responsible for any co-payments, co-insurance amounts, deductibles and non-billable charges such as late cancellation/no show fees.

You will be responsible for payment of all services that are denied by your insurance either due to benefit limits, non-covered services and/or services that your insurance deems not medically necessary or investigational. We are not participating with Medicaid, therefore if your child has Medicaid as a secondary insurance carrier you will be responsible for any remaining charges after your primary insurance has processed the service. Also, you will be charged **$25.00** for any returned checks.

If you have an insurance carrier with which we are not a contracted provider, we will courtesy bill for you, but it will be your responsibility to follow up with your carrier to ensure payment.

Our fees are as follows:

- **Evaluation:**
  - $240 **OR**
  - $225 (discounted) if paid 'in full' on the ***DATE*** of service
- **Therapy:**
  - $140 **OR**
  - $126 (discounted) if paid 'in full' on the ***DATE*** of service

If you have any questions or concerns regarding your bill, please contact our billing department at 1.888.698.6488 or at www.billing@medipostinc.com.

The signature below confirms that I agree to pay according to the conditions stated above.

_____ _____

Signature **date**

revised 5.16.11