

APTC Payment Policy

_____ I understand that an authorization from my insurance company does not guarantee payment from my insurance company, and I am responsible for any amount denied or unpaid by my insurance company.

_____ I understand that I am responsible for notifying the office staff of any changes to my personal information including insurance. I will also be responsible for any fees or denied insurance claims that may result from my failure to provide the office staff with correct and up to date information.

_____ I understand that I may be asked to assist the office staff in obtaining authorizations/ benefits from my insurance company. It is my responsibility to provide accurate information regarding insurance and, if needed, be a liaison between this office and the insurance company.

_____ I understand that APTC collects payment up front on the date of testing and I will first receive a call letting me know about any initial balance unpaid. **I understand that, once insurance processes (if applicable), there may still be an outstanding balance for which I am responsible to pay. If this is the case, I will receive another invoice (or call) for the final outstanding balance. In the event that there has been overpayment, I will be issued a refund.**

_____ I understand that if I choose to have testing processed before APTC has been able to obtain authorization from my insurance carrier, then I am responsible for payment in full before services are rendered and/or should it not get approved for any reason.

*****APTC reserves the right to submit unpaid balances to a collection agency in the event of nonpayment within six months of the evaluation appointment.*****

Additional Fees

_____ I understand that a failure to cancel or reschedule my appointment within at least **48 business hours** notification to the office staff will result in a **\$100 No-Show/Late Cancellation** fee charged to my account. I must pay any No-Show fees before I can be seen for any follow-up appointments.

_____ I understand that phone conversations are not billable under the insurances. If I need a phone consultation, I am responsible for the fee which is \$100.00 per hour and can be prorated.

_____ I understand that if I have additional paperwork to be completed regarding accommodations for academic institutions, I will be required to pay an extra fee out of pocket, as this would be in addition to the psychological evaluation conducted and is not covered by insurance. This fee ranges between \$25-50 based on time required to complete the documentation by the clinician.

_____ I understand that academic testing (i.e. learning disorders) is NOT covered by any insurance. If academic testing is requested, I am responsible to pay this charge out of pocket.

_____ I understand that there will be a \$25 fee for all returned checks.

_____ I understand that there will be a \$15.00 charge for medical records if I request them 1 year or longer after the initial receiving of them.

Legal/Court Matters

Consultations/Communications

_____ I understand that APTC does not conduct evaluations related to custody/visitation/fitness to parent or court-order.

_____ I agree that in any child custody/visitation proceedings, neither parent will seek to subpoena APTC records or ask APTC employees to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing APTC opinion about parental fitness or custody/visitation arrangements.

**Please note that your agreement may not prevent a judge from requiring APTC testimony, even though APTC will not do so unless legally compelled. If APTC employees are required to testify, they are ethically bound not to give opinions about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, APTC will provide information as needed, if appropriate releases are signed or a court order is provided, but APTC will not make any recommendation about the final decision(s).

**If an APTC employee is required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for APTC participation agrees to reimburse APTC at the rate of:

_____ \$250 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

_____ Each hour of preparation, travel, phone consultation, or email correspondence, is billed as a complete hour at the minute the hour begins; there are no increments of hours billed.

_____ The minimum fee for testimony/appearance is \$2000 PER DAY until released by the court, regardless if testimony was made.

_____ Court appearance, of any kind, canceled without a minimum of 48-hour notice Monday-Friday 8 am- 5 pm will be billed \$2000.00. Cancellations after 5 pm Friday will be considered a cancellation given on the following Monday 8 am.