SERVICES OF ROBERT D. GREGORY, PH.D.
FEE AGREEMENT

I charge $180.00 for an initial appointment because of the additional time and expense involved in gathering the information necessary for opening a record. After the initial appointment I charge $160.00 for 45-minute appointments. Fees for psychological testing involve time to score and interpret the tests. I also charge this amount for other professional services you need, though I will charge a pro-rated fee for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries necessary for the authorization of services by insurance or managed care companies, and the time spent performing any other services you may request of me. If you do not show for your appointment or cancel your appointment with less than 24 hours notice you will be charged for that session. Twenty-four hours notice that you will be missing your appointment is important because I can usually fill the time that had been saved for you with someone else who is wanting to be seen. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If you are late for an appointment you will be expected to pay for the portion of your appointment that you missed.

My fee for marriage therapy is $190.00.

Fees may be raised only after informing the patient (or the responsible person if the patient is a minor).

When seeing children whose parents are separated or divorced, the parent initiating the service with me will be financially responsible. I do not bill another person or an estranged spouse unless that person notifies me in writing that he or she is accepting payment responsibility.

Payment for services is due when services are provided. As a courtesy to my patients and families, I will bill your insurance company in accordance with information you provide to me. **However, you (not your insurance company) are legally responsible for full payment of my fees.** You are expected to pay any deductible or co-pay required under your insurance plan, at the time of service. If your insurance company sends the payments to you instead of me because I am not contracted with them, you are expected to pay in full at the time services are provided.

A monthly service fee of $10.00 will be added to any balance outstanding for more than 60 days.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If legal action is necessary, its costs will be included in the claim.

My signature below indicates that I have read and understand this fee policy. I agree to take responsibility for fees charged to the account of ________________________________.

(Patient Name)

______________________________________ ______________________________________

(Signature) **(Date)**