PATRICIA VELKOFF, PH.D., P.C.
CLINICAL PSYCHOLOGIST, 243 CHURCH STREET, NW SUITE 300-A, VIENNA, VIRGINIA 22180-4434

FINANCIAL AGREEMENT

Patient Name:			
Patient DOB:		**Patient SSN:**	
Address:			
Responsible Party Name:			
Responsible Party DOB:		**Responsible Party SSN:**	
Address:			
Employer Name:			
Employer Address:			
Home Phone:		**Other Phone (specify):**	
Office Phone of _____:		**Office Phone of _____:**	
Cel Phone of _____:		**Cel Phone of _____:**	
email address of _____:		**email address of _____:**	
Other Phone/Fax:		**Other Phone/Fax:**	
Insurance Carrier:		**Referred by:**	

FEES

Diagnostic Evaluation (75-90 minutes)	$280.00-400.00	Psychological Testing, Full	$2,856.00
Therapy (Individual or Family, 50 minutes)	$180.00	Psychological Testing, Partial	varies
Forensic Fee (testimony: four hour minimum)	$575.00/hour	Additional services (telephone consultations, letter writing, etc.)	$180.00/hour
School Observation or home visit (including travel time), per hour	$ 180.00	Late Cancellations & Missed Appointments (these are not reimbursed by insurance)	$180.00/hour

MEDICAL INSURANCE

I am responsible for reviewing my insurance coverage and for notifying Dr. Velkoff of insurance requirements such as: precertification for treatment or testing; required reviews of treatment; limitations on treatment by number of sessions, types of therapy, diagnoses, or monetary amount per year or lifetime.

I authorize Dr. Velkoff to release information concerning my treatment to my insurance carrier in accordance with federal and state laws. Information is limited to: dates of service; session start and stop times; type of therapy; results of clinical tests; and summary of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. I understand that I can restrict disclosure of this information to my insurance carrier and that Dr. Velkoff can refuse to provide services if she feels that such a restriction would jeopardize her judgment or my treatment. I will file my own insurance claims unless my insurance *requires* that they be filed by Dr. Velkoff.

I acknowledge full responsibility for this account and guarantee payment of the charges. Interest of 18% annually will be charged for any balance 30 days overdue, and I agree to pay for all costs of collection, including, but not limited to, bank charges, court costs, attorney fees, and collection agencies. All claims arising from this contract shall be adjudicated in the court of the Commonwealth of Virginia, or the federal courts located in Alexandria, Virginia.

_____ _____ _____

Patient (or Parent/Guardian) Date Witness Date