PATRICIA VELKOFF, PH.D., P.C.
CLINICAL PSYCHOLOGIST, 243 CHURCH STREET, NW SUITE 300-A, VIENNA, VIRGINIA 22180-4434
PHONE: 703-938-6100; **WEBSITE**: WWW.PATRICIA-VELKOFF.COM; **FAX**: 703-938-8393

FINANCIAL AGREEMENT

Patient Name:			
Patient DOB:		**Patient SSN:**	
Address:			
Responsible Party Name:			
Responsible Party DOB:		**Responsible Party SSN:**	
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)	$295.00	Forensic Fee (testimony: 4 hr./minimum)	$625.00/hour
Therapy (Individual or Family, 50 minutes)	$190.00	Additional services (telephone consultations, letter writing, etc.)	$190.00/hour
Therapy (Individual or Family, 30 minutes)	$125.00	Late Cancellations & Missed Appointments (these are not reimbursed by insurance)	$190.00/hour
School Observation or Home Visit (including travel time), per hour	$190.00		

MEDICAL INSURANCE

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

If I will be applying for insurance coverage, 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; test results; and summary of diagnosis, functional status, treatment plan, symptoms, progress to date, and prognosis. 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 60 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.

____ ____________
Patient (or Parent/Guardian) Date