everbreeze

Patient Financial Responsibilities and Other Information

PLEASE READ CAREFULLY AND SIGN/DATE AT THE THREE DESIGNATED PLACES.

CANCELLATION POLICY: If I would like to reschedule or cancel an appointment, I will call at least 24 hours before the appointment. Failure to do so will result in a missed session fee, equivalent to the cost of a full session. Insurance will not cover missed session fees.

Signature: _____

RELEASE OF INFORMATION: Everbreeze Psychological Services, LLC, and/or Dr. Corinne Lewkowicz have my permission to speak with and to release information to my other health care providers and/or my insurance company regarding my psychological treatment, and reimbursement of my healthcare costs.

Signature: _____

PATIENT FINANCIAL RESPONSIBILITIES AND OTHER INFORMATION

- I hereby authorize payment directly to Everbreeze Psychological Services, LLC, and/or Dr. Corinne Lewkowicz for psychological services rendered to me.
- I recognize and accept responsibility for paying the appropriate payment or co-payment at the time of my appointment.
- I authorize Everbreeze Psychological Services, LLC, and/or Dr. Corinne Lewkowicz to release mental health information to my insurance company pertinent to reimbursement for my mental health care.
- If Everbreeze Psychological Services, LLC, and/or Dr. Corinne Lewkowicz receives rejection of payment because of my not reporting a selection or change of a primary care provider (PCP), I will be responsible for the charges incurred for the date(s) of service.
- I should be aware of what services my insurance company covers. If I authorize/accept a service and it is not a covered service, I am responsible for the payment.
- Questions regarding an increase in co-payment, co-insurance, or deductible amount, will be directed to my insurance company, as will any questions about my insurance policy.
- If my insurance company requires authorization for services, it is my responsibility to contact the company for the authorization. If Everbreeze Psychological Services, LLC, and/or Dr. Corinne Lewkowicz does not receive this authorization within 24 hours of the visit, I will be responsible for full payment of these services.
- This agreement shall remain in effect indefinitely unless changed in writing by the patient, parent, guardian, or guarantor.
- I have read, understand and agree to the above.

Print Name: _____

Patient's/Parent's/Guardian's Signature: _____ Date: _____