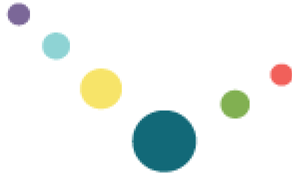


Jocie Sweeney, PhD

Your Charlotte Psychologist

Licensed Psychologist
980.236.0734
801 East Morehead Street, Suite 103
Charlotte, NC 28202
drsweeney@sweeneypsych.com
www.sweeneypsych.com

Financial Policy & Review of Consent Agreement

Please review this Financial Policy, which describes Dr. Sweeney's schedule of fees for therapy services, charges not covered by insurance, and additional fees. Please be sure you understand the policies regarding cancellations and missed appointments, methods of payment, insurance reimbursement, and past due accounts. If you have any questions about anything, please ask Dr. Sweeney prior to signing this form.

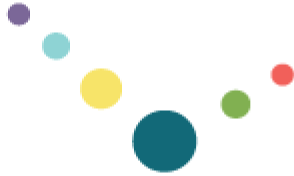
Service	Procedure Code	Fee
Diagnostic Evaluation	90791	$155.00
Individual Psychotherapy (60)	90837	$155.00
Individual Psychotherapy (45)	90834	$135.00
Psychotherapy Consultation (30)	90832	$85.00
Group Psychotherapy Screening (30)	90832	$45.00
Group Psychotherapy (90)	90853	$60.00
Late (less than 24-hour) Cancellation		$55.00
No-Show		$155.00
Records Request		$15.00
Insufficient Funds (bounced check)		$40.00
Case management*	Pro-rated per 15 min	$135.00

* this includes indirect services provided outside of our session time such as completing forms/reports, writing letters, requested consultations (for which a written release of information is required), and coordination of other services.

Payment

You will be expected to pay for each session in full at the time of services provided*. Accepted methods of payment are cash, check, or credit cards. Checks should be made payable to Jocie Sweeney, PhD. Checks returned due to insufficient funds will incur a fee of $40, which will be charged to your credit card on file. By signing this form, you are giving Dr. Sweeney permission to charge your credit card for any services that have not been paid within 15 days of billing. You are also giving Dr. Sweeney permission to charge your card for late cancelation and no-show fees on the day of your appointment. Dr. Sweeney will notify you by email when she submits the charge. At the time of your appointment, PLEASE PROVIDE your insurance card (if applicable), license, and CC so that Dr. Sweeney may make a copy for your file.

*When using insurance, you are expected to pay your co-pay/co-insurance at the time of service. If you have not yet met your deductible, you will be responsible for the full session fee.



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Credit Card on File

Name ______________________________

Cardholder Name ______________________________

Billing Address ______________________________

____

Credit Card Type ______________________________ Expiration Date ______________

Credit Card Number ______________________________ CVV (3 digit code on back) ______________

Signature ______________________________

Your initials indicate that you agree with the following (initial each one that you agree with):

_____**Limits of Confidentiality** (all shared information is confidential within the limits listed on the Policies form)

_____**HIPAA** (personal healthcare information is protected with some exceptions)

_____**Payment for Services** (payments are due after each session)

_____**Insurance Reimbursement** (you authorize me to bill your insurance company- if applicable)

_____**Cancellation** (24 hours notice without charge; otherwise, charged $55 for cancel or $155 for no-show)

_____**Telephone Calls and Electronic Mail** (you agree to telephone and email correspondence)

_____**After-Hours Emergencies** (described in the policies form)

_____**Consent to Treatment** (you are voluntarily participating in therapy)

______________________________ ______________________________

Client Name (or Guardian Name) Client Signature (or Guardian Signature)

Date:_________________________

____

Jocie Sweeney, PhD