Kristen Smith-Simon, Ph.D.
454 Rolling Ridge Drive, State College PA 16801
Ph. (814) 235-1100 x107 Fax (814) 235-1101

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ DOB: _____

I accept full responsibility for payment of any services provided on behalf of me or my child(ren), including but not limited to psychological evaluations, treatment, consultations, and relevant written or verbal communications, according to the applicable rate schedule in effect at that time.

I am responsible for payment in full at the time of service. I will make prompt and complete payments.

In the case where I have insurance coverage that provides some reimbursement for certain services, I will pay my portion or co-pay at the time of service, and may still be responsible for any additional payments not covered by my (or the child's) insurance at a later date.

In the event that Kristen Smith-Simon,Ph.D. files insurance on my behalf, I hereby assign all health insurance benefits to which I am entitled to Dr. Smith-Simon. I further authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original.

I understand that if Dr. Smith-Simon is a provider in my insurance's network, I am responsible for providing correct and complete information about all policies covering the patient. I will be responsible for paying any claims that are rejected due to my failure to provide correct information in a timely manner.

Primary Insurance Company: _____

ID Number: _____ Group Number: _____

Subscriber Information:

Name:_____ Relation to Patient: _____

DOB:_____ SSN: _____Phone #: _____

Address: _____

Employer: _____

Secondary Insurance Company: _____

ID Number: _____ Group Number: _____

I authorize billing correspondence including monthly statements to be sent to me via the following

Email:_____

I understand and agree that if my account becomes overdue, I may be subject to collection proceedings as allowed by law.

I agree to these terms for the duration of services, unless otherwise agreed to in writing.

_____ _____

Print Name of Financially Responsible Party Relation to Patient

_____ _____

Signature of Financially Responsible Party Date