DEBORAH J. RIBNICK, PhD, PC

5595 Kietzke Lane, Ste. 110e Reno, Nevada 89511 - 5513

FINANCIAL INFORMATION

PLEASE REVIEW / COMPLETE THIS ENTIRE FORM, EVEN IF YOU ARE NOT USING INSURANCE.

PLEASE PRINT LEGIBLY DATE _____ / _____ /_____

CLIENT'S NAME _____ SS # _____ DOB _____

CLIENT'S ADDRESS: _____
STREET CITY STATE ZIP

PERSON(S) RESPONSIBLE FOR PAYMENT _____

RESPONSIBLE PARTY'S (INSURED'S) ADDRESS _____
(If different from client's address) STREET CITY STATE ZIP

PHONE (H) _____ (W) _____ (C) _____
(CONFIDENTIAL YES / NO) (CONFIDENTIAL YES / NO) (CONFIDENTIAL YES / NO)

PRIMARY INSURANCE _____ TEL: _____
Provide the claims / billing address, only if you do not have your insurance card. It is best to provide your card to Dr. Ribnick

ADDRESS _____ POLICY #_____

INSURED'S NAME _____ RELATIONSHIP TO CLIENT _____
(If different from client's)

INSURED'S EMPLOYER _____ SS # _____ DOB _____

SECONDARY INSURANCE _____ TEL: _____
Provide the claims address, only if you do not have your insurance card. It is best to provide your card to Dr. Ribnick

ADDRESS _____ POLICY #_____

(No need to complete the following information if it is the same as client's information, or already noted in primary insurance section)
INSURED'S NAME _____ RELATIONSHIP TO CLIENT _____

INSURED'S EMPLOYER _____ SS # _____ DOB _____

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

You are responsible for payment of Dr. Ribnick's full fee at the time of service, unless other arrangements have been made. If utilizing insurance, Dr. Ribnick will directly bill the insurance company for its share of the fees, only in cases of financial hardship or upon mandate by the insurance policy. All co-payments & deductibles are still due at the time of service. Correct change is appreciated. If your insurance coverage changes, please notify Dr. Ribnick immediately.

The insurance policy is a contract between the insurance subscriber and the insurance company. Dr. Ribnick is not a party to that contract. If the insurance company has not paid your account within 45 days, you will be held responsible for your bill. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance policy. <u>You are responsible for knowing what is covered by your insurance company</u>; please feel free to request assistance from Dr. Ribnick on this matter.

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CHARGES FOR SERVICES All listed rates are subject to change at a future date.

Diagnostic / Initial Therapy …….	$200 per hour
Individual Therapy …….	$160 per hour
Couple / Family Therapy …….	$160 per hour
Inpatient or Residential Individual, Couple/Family Therapy ……	$180 per hour
Psychological Testing …….	$235 per hour
Charges include: test administration, scoring, interpretation, and report writing	
Travel time …….	$160 per hour
Telephone calls to you or on your behalf (over 5 minutes) ….	$160 per hour
Written correspondence on your behalf …….	$200 per hour
Record review and consulting with other providers ……..	$160 per hour
Consultation and Evaluation ……..	$235 per hour
Charges include interview and report preparation time	
Court appearances / depositions and related preparation …	$375 per hour (3 - hour minimum)

Note: The cost per therapy hour is defined as a "50-minute hour" – the typical session length is **50 minutes**. Extended sessions will be pro-rated according to the amount of time actually spent.

Checks are to be made out to Deborah Ribnick, Ph.D.. A charge of $35.00 exists for returned checks. Visa and Mastercard payments are accepted, however, a 4% processing fee will be added to the bill.

Insurance billing services are provided in circumstances of financial hardship or as otherwise agreed in advance. In such cases, Vitals, Inc. will provide this service for Dr. Ribnick. You may contact Diana Sutherland if you have questions at (775) 825-2777.

Arrangements for delayed or alternative payment plans can be made on an individual basis, in cases of financial hardship.

CONTRACT FOR SERVICES

I have read and understand Dr. Ribnick's financial policies, and hereby authorize her to provide psychotherapy or psychological services to the identified client. I understand that I am responsible for all payment of all services, regardless of insurance coverage. I also understand that in the event of a delinquent account, a collection agency may be notified and that my name / the client's name, address, and financial statement would be made available for this purpose. Any outstanding fees will be charged the legal interest rate (generally the prime rate plus 2%), compounded monthly. In the event outstanding fees exist, and it is necessary to institute a collection action against you, for the collection of fees and costs due to Dr. Ribnick, you will pay, in addition to any judgment for such fees and costs, all costs and expenses necessitated thereby. I further understand I will be charged for any missed or cancelled appointments at the rate of the normal office visit, unless the appointment is cancelled at least 24 hours in advance. Dr. Ribnick has a time and date-stamped voicemail system that is available 24 hours per day. This charge is not billable to the insurance company but is my responsibility.

INSURANCE AUTHORIZATION OF PAYMENT TO PROVIDER

I authorize payment of medical benefits to Dr. Deborah Ribnick for psychological services provided. I further authorize Dr. Deborah Ribnick to release required information to my insurance company for the purpose of processing of my insurance claim.

_____ _____ _____ _____

Signature Date Signature Date

Relationship to Client: Client / Parent / Guardian / Spouse or Partner (please circle one for each person signing this form)

_____ (Initials) I request a copy of this form _____ (Initials) I have received a copy of this form