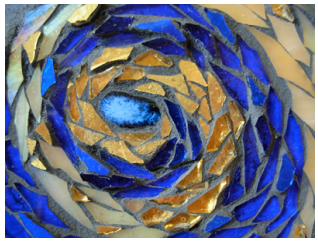

Jason A Johnson, PsyD

Clinical Psychologist

1020 SW Taylor St., Suite 245
Portland, OR 97205

503-853-4998
jasonajohnsonpsyd@gmail.com
www.jasonajohnsonpsyd.com

Insurance Agreement

Client Name: _____ Date of Birth:_____

Responsible Party (Bills will be sent to this individual)

Name:_____ DOB:_____ Gender: Male Female

Address:_____ Phone Home _____
(street)

_____ Mobile _____
(city) (state) (zip)

Work _____

Insurance Company: _____

Insurance Member ID:_____

General Financial Policies: With a few exceptions, I do not contract with private health plans. This means financial agreements are established directly between myself and clients, and not between myself and third party companies (unless specifically identified as part of a network). The client therefore assumes financial responsibility for professional fees accrued over the course of psychological services.

In general, my hourly rate is **$275** unless another fee agreement was previously arranged. Unless other arrangements are made in advance, payment in-full is expected the day services are rendered. If you are using third-party insurance companies, any unmet deductibles or co-payments will be due the day of the service.

Insurance Coverage for Psychological Services: Although I have opted to be an *out-of-network* provider with some private insurance plans, many health plans include out-of-network benefits. For other plans I am *in-network.* Additionally, since I am a psychologist resident many insurance plans do not allow me to bill them directly for my services. I am able to provide you with an invoice that you may be able to turn into your insurance company for reimbursement.

If you choose to use your private insurance company I cannot predict the exact amount of reimbursement any specific plan will provide. Therefore, you are strongly encouraged to contact your health carrier prior to initiating services, to discuss coverage for psychological services (*CPT Codes*: psychiatric diagnostic evaluation (90791); psychotherapy (45 min-90834; 60 min.- 90837), to obtain a quote regarding benefit levels they will reimburse. If you desire, I can provide you with an invoice for you to submit directly to your insurance company for reimbursement; however, payment for services are due directly to me the day of service. Insurance companies that reimburse for invoices send the payments directly to the client, and should not be given to me.

Due to privacy concerns or other reasons, many clients decide to not use their private health plan benefits when obtaining psychological services. If, however, you do wish to pursue reimbursement for service cost from your private health plan, I will take any reasonable steps I can to assist you in accessing the benefits to which you may be entitled. Please indicate your payment/billing preference by checking the appropriate box below:

- ☐ I will **not** be using health plan benefits over the course of these psychological services, and I do not wish any information regarding my services, diagnostic status, or personal information to be released to a health insurance company or health plan. I understand I am personally responsible for paying service fees at the conclusion of each therapy session.

- ☐ I will submit a claim to my insurance company or health plan myself. I understand I am personally responsible for paying service feeds the day of the provided service.

- ☐ I authorize Jason A. Johnson, Psy.D., to submit a Health Insurance Claim Form (CMS-1500) to my insurance company or health plan and accept assignment of benefits. I authorize release of any details regarding presenting issues if requested by the health plan to establish "medical necessity" for services. I understand I am personally responsible for paying any service fees my health plan has established (deductibles and/or co-payments) the day services are provided.

  My signature below indicates I authorize (1) assignment of benefits to Jason A Johnson, Psy.D., and (2) release of any medical or other information necessary to process claims (including dates of services, types of services provided, diagnostic information, and/or any other personal information), as requested by my health plan. It also indicates I assume responsibility for contacting my insurance company to verify that I do indeed have coverage for psychological services to ascertain whether there are any "preauthorization" requirements, and to inform Jason A Johnson, Psy.D., of this information.

  _____ _____ _____

  Print Name of Insured Signature Date

Please note, I cannot guarantee that any specific insurance carrier or health plan will indeed authorize or disburse benefits payments, even if pre-authorization is obtained and a Health Insurance Claim Form is submitted. It is also not possible to guarantee that benefits paid will be the amount quoted by the health plan or equal to the expected by the client. For questions or concerns

regarding insurance benefits levels and/or a specific health plan's business practice, please contact the health plan directly. If your health plan is provided by your employer, you may also direct questions to your employer's benefits manager.

Fee Agreement: "By signing below, I assume full financial responsibility for fees for psychological services provided by Jason A Johnson, Psy.D. to or on behalf of _____(client's name). I personally agree to render full payment to Jason A Johnson, Psy.D. upon completion of the day psychological services are rendered, or to pay any outstanding deductibles unmet or co-payments. I also understand that Jason A Johnson, Psy.D. will refund any overpayment of fees directly to me within one business day of receipt."

_____	_____	_____
Print Name of Client/ Responsible Party	Signature	Date