Katie Dine Young, Psy.D
Licensed Clinical Psychologist

Financial Agreement

I understand that I am financially responsible for the payment (or insurance co-payment) of all charges rendered to me, or to any members of my family. I understand that all fees are to be paid at the time of each visit unless other arrangements have been made with Dr. Dine Young prior to receiving services.

My fees are as follows:

50 minute session = $140.00

90 minute session = $210.00

Late Cancellation/No Show = $50.00

Initial Consultation = 160.00

*I understand that insurance companies do not cover cancelled sessions. Therefore, ***$50.00 will be charged for missed appointments*** and appointments that are not cancelled within **twenty-four (24)** hours notice (excepting serious illness).

*I understand that if I am using **out-of-network benefits** a receipt with relevant information will be provided to you so that you can file for your benefits.

*I understand **that if using Humana**, a billing professional may be used to help receive payment from your insurance company and have access to some protected health information.

***To prevent services being rendered without payment, I will need your credit card number and expiration date on file. This number will only be billed if your account balance exceeds 30 days of date of service or if borrowed materials are not returned.**

_____ _____
Name on Credit Card Credit Card Number

_____ _____
Expiration Date CSV

I have read and understand the above statements.

Signature: _____ **Date:** _____