



Intuitive Psychology, PLC

...behavioral medicine for body, mind and spirit

5635 N. Scottsdale Rd., Scottsdale, AZ, 85250

Phone: (480) 261-4061

Fax: (480) 535-5548

Admin@IntuitivePsychologyPLC.com

## Professional Policy and Procedure Agreement

**Please read the following information very carefully** as it describes the policies, procedures, and related practices to be followed as a part of therapy services provided by Dr. Sari Roth-Roemer at Intuitive Psychology, PLC. This information is provided for your benefit and to facilitate your understanding of our policies and procedures as they apply to you. Please feel free to ask questions if you need to understand more about this relationship. After reading this material, please indicate your understanding and approval by signing this document, and giving it to your provider.

### **PAYMENT POLICIES**

Your Arizona Medical Psychology, PLC psychologist is an Arizona State licensed doctoral level psychologist. ***We are fee for service providers. This means that you pay for your services at the time you receive them and we will provide you with what you need to collect from your insurance company.***

We encourage every patient to verify their benefits for psychological services with their insurance company prior to their first appointment, so you will have a clear understanding of your benefits for out of network psychological services and what your financial responsibility will ultimately be. It is your responsibility to obtain any necessary pre-authorizations required to see Dr. Roth-Roemer before your scheduled appointment.

Insurance companies classify us as an out of network provider, except for Blue Cross. We do not bill any health insurance companies, other than Blue Cross. We collect full payment at the time of your visit and then your insurance company will reimburse you directly after you submit your charges to them. We provide receipts to submit to your insurance company for reimbursement. The receipts contain all the information a health insurance company would need to reimburse you for your visit. Reimbursement for psychological services are based upon your individual out-of-network benefits and coverage. Depending on your out of network benefit, you may be reimbursed for up to 80% of the appointment. Also, if you plan on billing insurance for reimbursement of your visit, you will need to obtain a prescription from your physician prior to your first appointment. If you do not plan on billing insurance, you do not need a prescription. For more assistance, please refer to our insurance billing worksheet to use when you contact your insurer.

**It is your responsibility to check to see what your insurance coverage is prior to your appointment with Dr. Roth-Roemer.**

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### **TELEPHONE THERAPY**

When therapy is provided over the telephone during or after office hours, you will be responsible for paying for these therapy services. Many medical plans do not cover these types of services and you should know that it is likely you will not be reimbursed.

### **CANCELLATIONS**

If you need to cancel an appointment, at least 24-hour notice is required. As a courtesy, our office will confirm appointments the day before the scheduled appointment. If you do not cancel at least 24 hours before your appointment time, you will be charged the full rate for the missed appointment.

### **ASSIGNMENT OF INSURANCE BENEFITS FOR BLUE CROSS PATIENTS**

I hereby authorize Intuitive Psychology, PLC to receive payment for services rendered to me, directly from my insurance plan, unless prohibited by my carrier for some reason. If the insurance company renders payment directly to me, I agree to forward the funds and a copy of the Explanation of Benefits to Intuitive Psychology, PLC, 5635 N. Scottsdale Rd, Scottsdale, AZ 85250. All payments must be made payable to Intuitive Psychology, PLC.

### **ACKNOWLEDGEMENT OF UNDERSTANDING**

I have read the information contained in the policies and procedures for Intuitive Psychology, PLC psychological services and acknowledge full responsibility for any charges incurred by me and or my family, regardless of insurance eligibility. A photocopy or facsimile of this authorization will be considered as valid as the original.

\_\_\_\_\_  
Patient/Guarantor Printed Name

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Date