Cashman Center
Therapies for Mind & Body

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Supplemental Billing Agreement Regarding Insurance Reimbursement (Part 2): Estimate of Uncovered Costs

Based upon the referral question and the information collected by your clinician, the recommended psychological assessment battery that is necessary and appropriate for your care consists of __________ hours/units of testing.

Upon the submission of prior authorization and/or the courtesy confirmation of your insurance benefits provided by Cashman Center, it is estimated that your insurance will cover ________ hours/units and that you will likely be responsible for ___________ units of psychological assessment. For psychological testing and evaluation services not reimbursed by your insurance carrier, you will be billed the full hourly rate for services ($225/hour).

The estimated out-of-pocket cost for the psychological assessment is $__________.

Please note that the information provided above is an estimate for the cost of psychological assessment services. It is possible that information discovered during the evaluation process may warrant the addition, substitution, or omission of psychological assessment measures based upon best-practice guidelines. Should this occur, it is possible that the rate billed may differ from the estimate provided above.

Your signature below indicates that you have read this document and agree to pay for all psychological testing and evaluation services not reimbursed by your insurance carrier. If you are unwilling to pay for these services, then you understand that your psychological assessment cannot continue as scheduled.

By signing below, I indicate that I understand and agree to the information above. I am agreeing to be "balance billed" for any hours not approved or reimbursed by my insurance company, whether in-network or out-of-network, for services rendered by Cashman Center.

Client or parent signature — Date

Client or parent printed name — Date

Clinician signature — Date

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