

JULIE ANN ALLENDER EDD  
Licensed Psychologist  
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**Office Policy and Financial Agreement**  
**Confidentiality**

The privilege laws require that all sessions be held in the strictest confidence. Under normal circumstances therapeutic material may be requested and released with the written consent of the client. Exceptions to this law are when duty to protect issues are brought to the therapist's attention, if the client is involved in a lawsuit or legal proceedings and the therapist is subpoenaed or requested to testify in court, criminal activities, for collection or billing purposes or if information is requested by patients' insurance company.

**Authorization of Treatment**

I authorize treatment for \_\_\_\_\_  
Print full name(s) of patient(s)

and agree to pay all fees and charges for such treatment. I understand that all balances are due and payable in full at time of service, although some fees may be delayed if Dr. Allender is submitting them to your insurance company. I agree to pay all charges promptly upon presentation of bill for any charges not covered by my insurance company, unless other credit arrangements have been agreed upon in writing.

Payment for each visit is requested at time of visit. Your receipt serves as proof of payment, services rendered, balance due and reminder of your next appointment. Charges for group cannot be waived. I understand that charges for the missed appointment are for full session amount, not just the copay amount. **All appointments require a 48-hour cancellation notice to avoid being charged. Cancellations must be made by phone, not email.**

Credit arrangements are subject to a monthly finance charge of 1.5% or a monthly rebilling charge whichever is higher. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date. I understand that I am responsible for all monies due including those in dispute with the insurance companies, any collection fees, finance charges and/or legal fees incurred in attempts to settle the account.

I agree to sign a release for myself and members of my family if Dr. Allender is filing with my insurance company and leave an active credit/debit card as collateral in case of default or balance due on my account.

It is agreed that payments will not be delayed or withheld because of any insurance dispute or waiting for claims to be paid. All proceeds of insurance are assigned to Dr. Allender where applicable. Dr. Allender may aid in collecting insurance reimbursement, without assuming responsibility for the collection thereof. If Dr. Allender is attempting to help collect insurance for me beyond the normal action of submitting the claim, I understand that there may be additional charges for letters, phone calls or other time incurred to help me collect the monies due. I understand that in these instances it is my responsibility to collect the monies due from my insurance company, not Dr. Allender's.

In the event legal action should become necessary to collect any unpaid balance due for psychological services for my family, or me I/we agree to pay reasonable attorney's fees, collection fees, finance charges or other such costs as the court determines proper. Dr. Allender will be happy to discuss fees and policies.

## Filing Insurance Claims

The financial responsibility for services rendered rests with the client or client's family, regardless of any insurance coverage. For those filing their own insurance, the receipt received at each visit has all the information on it that the insurance company needs. Simply attach it to the claim form. Fill out your portion and mail it directly to the insurance company. Dr. Allender's signature is not required on the claim form. Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claim. If it is not paid, the insurance company should explain to you why it was rejected. We look to you for payment, not to the insurance company. For certain insurance programs, Dr. Allender will file the insurance form for the client. Again, this does not mean Dr. Allender is responsible for your contract with the insurance company. She will do everything possible to help you collect the fees. Please be aware Dr. Allender provides this service free of charge under most circumstances. Your help to make this process simple is appreciated.

## Appointments

1. All sessions are 45 minutes and end at 10-15 minutes before the hour. Example: 9:45
2. MMPI required of ALL new clients.
3. Any client scheduling appointments six (6) weeks or more apart is subject to initial diagnostic evaluation fee. (The fee charged for first time clients.)
4. **All appointments require a 48-hour cancellation notice to avoid being charged. Cancellations must be made by phone or in person. No email cancellations are accepted.**

**NOTICE:** *Do not sign this agreement before you read and agree to the conditions set forth above. You are entitled to a copy of the agreement at the time you sign. Keep it to protect your legal rights.*

**I agree to the terms and acknowledge receipt of a copy of this form.**

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Both parents need to sign if a minor)  
(Parent or Guardian if under 18)

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or Guardian if under 18)

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

I plan to make payment of my psychological expenses as follows:

Check one: ( ) Cash ( ) Check ( ) Credit Card