DIANE E. SHOLOMSKAS, PH.D.

Phone: 203-776-2077 Fax: 203-248-2078

BILLING INFORMATION AND PAYMENT POLICY

As your doctor I am prepared to assist you in working with your insurance company. However, it is necessary for you to provide insurance information in a timely manner so that recertification, if necessary, can be obtained. Insurance will deny any claims not authorized or not filed within your insurance policy time limit. Also, it is important for you to be aware that most insurance companies require information about your diagnosis and treatment before they will pay for your treatment.

Please be prepared to pay your co-pay at each appointment.

I require 24 hours notice if you need to cancel an appointment. Insurance does not pay for missed appointments. Therefore you will be responsible for charges for missed or canceled appointments without 24 hours notice. If you were scheduled for a full session you will be charged the full session rate for the scheduled time. It is expected that you pay for the missed session at your next scheduled appointment.

If you decide not to use your health insurance, please talk with me about payment.

Please sign both statements.

1. I authorize Diane E. Sholomskas to communicate necessary and confidential information about me to my health insurance company regarding my therapy.

______________________________________ ______________________

Patient or Parent/Guardian’s Signature Date

2. I understand it is my responsibility to provide insurance information or call for pre-approval of services in a timely manner so that recertification, if necessary, can be obtained and claims can be submitted promptly. If claims are denied because I did not give necessary insurance information, I understand I will be responsible for these unpaid sessions.

______________________________________ ______________________

Patient or Parent/Guardian’s Signature Date