Grew, Morter & Hartye PA
3141 John Humphries Wynd, Suite 275
Raleigh, North Carolina 27612

GMH PROFESSIONAL FEES + FINANCIAL RESPONSIBILITY

SERVICES FEES

INTAKE (DIAGNOSTIC) INTERVIEW (First visit)	**$180**
Lisa Caprioli	**$145**
THERAPY SESSION (38 to 52 minutes)	**$160** (for each psychologist present)
Lisa Caprioli	**$125**
AUTISM SPECTRUM CONSULTING	**$90 per hour**
ADHD/ADD COACHING	**$90 per hour**

ASSESSMENTS FEES

Psychological Testing Administration/Scoring	**$200 per hour**
Psychological Testing Evaluation – (e.g., Integration, Treatment Planning, Reporting)	**$200 per hour**
Pre-Kindergarten Testing (with report)	**$600**
Document Preparation Fee (e.g. disability, life insurance forms)	**$50 per 15-minute increment**

PSYCHOLOGICAL TESTING – INSURANCE COVERAGE

Please note that your insurance company may restrict some or all of the psychological tests we administer, or may limit the amount of psychological testing that they will cover. Academic or intelligence tests and written reports are typically not covered by insurance. Payment for testing services that are either not covered or limited by your insurance company is due at the time of each testing session.

THE NEUROFEEBACK CLINIC at GMH - SERVICE AND ASSESSMENT FEES

NEUROFEEDBACK INTAKE/ASSESSMENT	**$150**
MINI-QEEG - with interpretive session (Assessment)	**$200**
NEUROFEEDBACK (Service)	**$90 per session**

CONSULTATION FEES

PHONE CONSULTATION (non-emergency): **$50 per 15-minute increment**
Free consultation and referral services are available from Holly Hill Hospital Response Line at 919-250-7000.

COURT PREPARATION/APPEARANCES:	**$500 per 60-minute** (to the attorney issuing the subpoena or to the person signing this form)
COPY OF RECORDS:	**$1.00 per page**, unless applicable law restricts charging the requesting party of copies of records

OTHER FEES

COPAYMENTS/CO-INSURANCE/DEDUCTIBLE:	Copayment, coinsurance, or deductible amounts for services rendered are due at the time of service.
LATE CANCELLATION-MISSED APPOINTMENT FEES (If minimum 24-hour notification of cancellation not provided)	**$69 for In-Network** **$100 for Out-of-Network and Self-Pay** **$90 for Neurofeedback sessions** **$90 for Autism Spectrum Consulting sessions** **$90 for ADHD Coaching sessions**

Please Choose One:

□ I am choosing to receive **In-Network** services and to have GMH file insurance claims (Please complete In-Network Billing Agreement).

□ I am choosing to receive **Out-Of-Network** services. I understand GMH does not file out-of-network insurance claims, and I may file directly with my insurance company (Please complete Out-Of-Network Billing Agreement).

□ I have no insurance coverage or I am declining to use insurance and am choosing to **SELF-PAY** (Please complete Self-Pay Agreement).

FINANCIAL RESPONSIBILITY
ASSIGNMENT OF INSURANCE BENEFITS AND GUARANTEE OF PAYMENT

I authorize direct payment of all medical benefits (not to exceed regular charges for similar services) to the attending professional at GMH or to whom the attending professional at GMH designates. I also authorize direct payment of all other medical benefits for services rendered to GMH. The benefits hereby assigned shall include, but not be limited to, major medical insurance, workers' comp insurance, insurance under a disability insurance policy, or any other applicable insurance coverage under which I am in the insured. I understand that unless my insurance carrier has entered into a legally binding agreement enforceable against the attending professional, his/her designee, or GMH, as the case may be, which limits my responsibility for payment, I am personally responsible to GMH, the attending professional and/or his/her designee to pay for all charges not paid for by insurance, including, but not limited to charges for health care services determined to be non-medically necessary by a private insurer's utilization review program.

The undersigned, on behalf of himself-herself personally, and on behalf of the client of GMH, in consideration of health care services rendered, or to be rendered, by GMH to the client, agrees to pay upon demand, and guarantees payment to GMH of all of GMH's regular charges as set forth in this GMH Professional Fees Sheet (as revised) for services, medicine, supplies and incidentals provided to or on behalf of the client, subject only to an agreement, if any, between the client's insurance carrier and GMH that provides for difference charges; and the undersigned further expressly agrees, both on behalf of himself-herself and the client, the undersigned and the client will provide GMH with the name and address of each carrier, each policy and each claim number, to pursue claims when applicable. Additionally, in the event of copayment, the undersigned and the client agree to pay, and do hereby guarantee payment of, all costs of collections, including reasonable attorneys' fees.

____ _______________
Printed Name of Client or Personal Representative **Date**

____ _______________
Signature of Client or Personal Representative **Date**

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Capacity of Personal Representative (e.g. Parent, Guardian, etc.)

NPP ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of the Notice of Privacy Practices for Grew, Morter & Hartye PA

____ _______________
Printed Name of Client or Personal Representative **Date**

____ _______________
Signature of Client or Personal Representative **Date**

____
Capacity of Personal Representative (e.g. Parent, Guardian, etc.)