NANCY IREY HOLMES, PSY D, CBIS
Licensed Psychologist
Portland: (503) 235-2466 Redmond: (541) 330-4428
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FEE AGREEMENT AND INSURANCE INFORMATION

Fees: The standard service charge is $225 for an initial consultation, $150 per 50 minute office appointment and $225 per 90 minute office appointment. Longer sessions are prorated at the same hourly fee.

Please *check* one of the following:

_____ **1) SELF-PAY:** I agree to pay in full at the time of service.*

*Exception: If we have agreed on this, the fee for treatment will be $_____ per session. I agree to pay at a minimum rate of $_____ per week/month until the balance is paid in full.

_____ **2) INSURANCE:** The following information must be completed and verified. It is important for me to estimate what your insurance, if any, will cover and for what length of time. This may affect our treatment goals and the frequency of treatment which must be appropriate to your needs.

Name of Client:_____ Client's Date of Birth:_____

Name of Person Insured: _____ Insured's Date of Birth: _____

Client's Relationship to Insured: _____

Insured's Mailing Address: _____
Address City, State & Zip

Insured's Home Phone: _____ Work Phone:_____

Insured's Employer: _____ Effective Date of Coverage: _____

Primary Insurance Co.: _____ Phone: _____

Is there another insurance company who manages your mental health claims? Yes ❑ No ❑

If so, please provide name & phone number:_____

Address to Send Mental Health Claims: _____

_____

_____

Subscriber #: _____ Group #: _____

Policy # (if any): _____ Visits/calendar year or other time frame: _____

Number of Mental Health Visits in this Time Frame: _____ Annual Deductible: $_____

Deductible Remaining: Yes ❑ No ❑ Co-Pay required per visit? Yes ❑ No ❑ Co-Pay Amt. $ _____

Is my fee within your insurance company's range?* Yes ❑ No ❑ Specify amount covered: $ _____

* Sometimes my fee exceeds the insurance company's allowance and in most cases you will need to make up the difference.

If necessary, have you received pre-authorization? Yes ❑ No ❑ Pre-Authorization #: _____

Total Outpatient Mental Health Benefit: $_____ Specify Details: _____

_____

_____

Do you expect your health benefits for change in the near future? Yes ❑ No ❑ If so, please explain:

_____

_____

In many cases, after the initial consultation I will bill directly to your primary insurance company for the portion of the bill they will cover. However, it is your responsibility to bill any secondary insurance you may have. Because of the delay in reimbursement, in most circumstances I request that you pay directly for costs not covered by your primary insurance. If necessary, you will be provided with a bill that you can submit to your secondary insurance or flexible spending plan.

Secondary Insurance Co.:_____ Phone:_____

Insured's Name:_____ Subscriber/Policy #:_____

Group #:_____ Address:_____

I have read, understand and agree to the terms of this form. By signing this form I authorize the use of the signature(s) below on all insurance submissions and also authorize the payment of medical benefits to Nancy Irey Holmes.

_____ _____

Client Signature **Date**

_____ _____

Client Signature **Date**

_____ _____

Parent or Guardian Signature if Minor Child **Date**