Dr. Tina Goodin, Ph.D., ABPP, CPS

Board Certified Clinical Psychologist

Patient Payment and Health Insurance Agreement

Thank you for choosing me as your provider. I am committed to providing you with quality and affordable mental healthcare. Please read the payment policy and initial before each numbered item and sign below

1. **Insurance. All patients must complete our patient information form before consulting with the provider. You must provide a copy of your driver's license and proof of currently valid health insurance. If you are not insured by a plan we participate with, payment in full is required at the time services are rendered. If you fail to provide us with the correct health insurance information in a timely manner, you will responsible for the entire fee. Knowing your health insurance benefits (coverage) is your responsibility. Please contact your health insurance company with any questions you may have regarding your coverage.**
2. **Co-Payments and Deductibles. All co-payments and deductibles must be paid at the time of service. The amount of co-payments and deductibles are mandated by your health insurance company.**
3. **Nonpayment/s. If your insurance is inactive, you are responsible for the bill. We will keep your credit card on file. If your insurance company states you have a balance, we will leave a message to let you know we will be charging your card on file for the amount the insurance states is your responsibility.**
4. **Missed Appointments. Our policy is to charge for missed appointments that are not canceled prior to 72 business hours of your appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointments.**

I acknowledge and confirm that Dr. Tina Goodin, is agreeing to provide mental health services to me in accordance with the contents of this Patient Payment and Health Insurance Agreement.

I have read, initialed, and understand the payment policy and agree to comply with its provisions

Signature of patient or responsible party **Date**