Emanuel Troiani, Psy.D.
Licensed Clinical Psychologist, Neuropsychologist
Certified School Psychologist

1018 N. Bethlehem Pike, Suite A-1
Lower Gwynedd, PA 19002

700 Horizon Circle, Suite 101
Chalfont, PA 18914
(215) 233-5688

FINANCIAL RESPONSIBILITY ASSIGNMENT

This form must be filled out by every patient (or another party claiming financial responsibility for the patient). This form may be used if someone OTHER THAN the patient is accepting financial responsibility for the patient (for example, if the patient is a minor or if the patient has limited capacity to manage their finances or make their own financial decisions). Please see page two for Financial Policies and Payment Terms.

TODAY'S DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT ADDRESS: _____

_____

PATIENT PHONE: _____

RESPONSIBLE PARTY NAME: _____
(write "self" if patient is responsible)

RESPONSIBLE PARTY'S ADDRESS: _____

_____

_____

RESPONSIBLE PARTY PHONE: _____

RELATIONSHIP TO PATIENT: _____

***By reading and signing this agreement, I agree to follow the Financial Policies and Procedures listed on both pages of this document and that I am taking financial responsibility for services provided to the above patient by Emanuel Troiani, Psy.D. and Emanuel E. Troiani, Inc. ("Provider").**

Signature: _____ Date: _____
(Responsible Party)

Received By: _____ Date: _____
(Office Use Only)

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Financial Policies, Payment and Assignment of Benefits:

***Returned checks will result in a fee of $35.00 billed to the patient.**

Although we are in-network with many insurance plans, the terms of individual policies can vary significantly, even within a particular insurance program. It is, therefore, ultimately your responsibility to contact your insurance company to understand exactly what your insurance covers and the requirements specific to your policy (co-pays, deductibles, referrals, limitations of benefits, etc.).

By signing this consent, you agree that you understand the following: The patient (or parent/legal guardian, if the patient is a minor) is responsible for any unpaid balance not covered by their insurance. In the event of an unpaid balance, dates of service and demographic information may be shared for collection. You acknowledge that it is your responsibility to know your insurance coverage details. If you need help understanding your insurance coverage and benefits, it is your responsibility to contact the office of Dr. Troiani, or your insurance provider, for further explanation.

You will be notified, by phone, of any financial responsibility PRIOR to the beginning of your testing (+the only exception is for co-pays; we will not know if you owe a co-pay until we receive the first Explanation of Benefits [EOB] from your insurance company). We will contact your insurance company to determine if you will owe anything out of pocket and we will communicate this to you. However, be aware that this is a good faith estimate based on what your insurance company tells us. If your insurance company processes your claims differently than we were quoted, it will be your responsibility to contact your insurance company and rectify the matter. Ultimately, you are responsible for any unpaid balance.

If you need to set up a Payment Plan, please notify the Practice Manager at least 3 business days PRIOR to your first appointment in our office. Payment Plans MUST be agreed upon with the Practice Manager BEFORE the testing begins or the *Default Payment Policy will apply (see below). No Payment Plans will be made once the testing has begun.

Payments are due by the Due Date on your invoice. There is a 10-day grace period after the Due Date to allow for postal service delays. However, if payment in full is not received by the end of the 10-day grace period, our system automatically transfers all delinquent accounts to Transworld Systems, Inc. for collection of payment (interest will accrue).

***Default Payment Policy:**

1) **If you are responsible for the entire amount of the testing, for example, if you do not have medical insurance or have a high deductible that applies to the service, one third of the total amount MUST be paid by the Intake Appointment (your first appointment) and the entire remaining amount due MUST be paid by the Feedback Appointment (your third/last appointment). You may start making payments at any time prior to your first appointment and we can break the payments down into smaller amounts, but at least one third must be paid prior to the Intake Appointment and your account must be paid, in full, by the Feedback Appointment (this does not include Payment Plan arrangements).**
2) **+If you owe a co-pay (usually an amount somewhere between $10-$100 per office visit, but may differ), you will be issued an invoice in which you can pay by cash, check, or credit card. The invoice will have a Due Date by which the payment must be received. The grace period and collections rules, as stated above, will apply.**
3) **If you owe co-insurance (usually 10-30%, but may differ), you will be sent an invoice in which you can pay by cash, check, or credit card. The invoice will have a Due Date by which the payment must be received. The grace period and collections rules, as stated above, will apply.**
4) **If your account is not paid in full by/at your Feedback Appointment, this may result in the rescheduling of your feedback appointment and the results of your testing may be delayed (this does not include payment plan arrangements).**