

Payment Agreement

HRC Behavioral Health & Psychiatry, PA

Patient: _____

It is my understanding that Mareah Steketee, PhD

- _____ Is a provider with my primary(secondary) health insurance
- _____ Is not a provider with my primary(secondary) health insurance
- _____ Is a Medicare provider
- _____ Is not a Medicare provider
- _____ Will not be billing any health insurance; *I will pay in full*
- _____ Will be paid by _____
- _____ _____

I further understand that if the service(s) I am currently seeking do not meet the criteria for my insurance and/or exceed their allowable hours, I will be fully responsible for those charges. Also, I will be responsible for the payment of any deductibles, copays, coinsurance or other costs associated with this requested service at the time of service unless another agreement is made.

Description of Service(s) _____

Reason(s) for Denial _____

My signature indicates that I have read and agreed to the above and accept this responsibility.

Patient/Guardian: _____ **Date** _____

Witness: _____ **Date** _____