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**_____

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