Carolina Psychological Associates Consent Form

I, _____ , give my consent for to receive educational/placement consulting services from **Carolina Psychological Associates, P.A.** I understand and agree to pay **$130.00** per hour for consulting services, **$130.00** per hour for psychological testing, **$300.00** for school placement research fee, **$300.00** for a scholarship search fee, and **for any appointments that are missed or canceled less than 24 hours in advance. A $20.00 fee will be charged for checks returned for non-sufficient funds. I understand that I am responsible for any fees incurred but disallowed for any reason by my insurance company, and for any agency fees/court costs involved in collecting on my past due account.** I understand that if I am unable to keep an appointment, I agree to notify Carolina Psychological Associates, P.A., with at least 24 hour advance notice. I agree that I am financially responsible for any phone calls longer than 15 minutes. Payment is required at the time services are provided; however, insurance information will be obtained at the first visit and insurance will be filed as a courtesy to me. Insurance will be filed for psychoeducational testing only!

Educational/placement consulting services may involve meeting with parents and/or the youth, reviewing educational, treatment, and medical records, and providing a minimum of 12 colleges (or 3-5 special needs program) for parents to visit and contact for their final choice. Parents and students are solely responsible for making the final choice of what they deem to be appropriate. Educational/placement consulting is not designed to be therapy or a substitute for therapy and treatment and cannot guarantee acceptance or the student's progress.

Release and Assignment: I hereby authorize any plan benefits to be paid directly to Carolina Psychological Associates, P.A., and I understand that I am financially responsible for non-covered services, including those for which authorization or payment is denied, either by EAP/Managed Care plan or payor. If a claim is made by me or by Carolina Psychological Associates, P.A., to any insurance company or companies, or to any third party payor, I do not object to the release by mail, fax, telephone or computer modem, any records or other information about my child, or the services which are provided, including, without limitation, the complete case record, information concerning any personal, psychological and medical history, information concerning the diagnosis and treatment by Carolina Psychological Associates, P.A., and information concerning billing and payment for such services. I agree that all such information shall be subject to review by such insurance company or third party payor during the period of my child's treatment by Carolina Psychological Associates, or at any time thereafter.

If the parents of this child are separated or divorced, and there is joint custody, I understand and consent to the other parents' notification of services of my child as advised by the N.C. Attorney General's Office.

_____
Parent or Guardian Signature Relationship to Minor

_____
Date