Jennifer Pechenik, PsyD, LCSW
Licensed Psychologist
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Financial Policy

Jennifer Pechenik, LCSW, PsyD, Licensed Psychologist, is committed to providing caring and professional mental health care to all clients.

Payments It is usual and customary for the provider and the client to agree upon Fees by the first session. As a client, you are expected to pay at the beginning of each session unless otherwise agreed upon. Initial consultations are 60 minutes long, subsequent Individual sessions are 50 minutes long. Double sessions are 1-1/2 hours in length. Telephone conversations, report writing, consultations with other professionals, releases, longer sessions, travel time, etc., will be charged at the same rate, unless other arrangements are made. Please notify me if any problem arises regarding your ability to make timely payments.

Payment Responsibility Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 120 days are subject to collections. A 1% per month interest rate is charged for accounts over 60 days.

Insurance deductibles and co-payments are due at the time of service.

Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first session at this office), this amount will be collected by the clinic until the deductible payment is verified to the clinic by the insurance company or third-party provider.

All insurance benefits will be assigned to this clinic (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate that would have been reimbursed should the payment been kept as scheduled.

If your co-pay changes, please advise Dr. Pechenik immediately as to maintain appropriate billing.

Payment methods include check, or credit cards.

By signing this agreement you are authorizing Dr. Pechenik to process applicable charges on your credit card. Please note that my company name is

TODAY'S WORLD CONSULTANTS, LLC.

And this is the name that you will see on our credit card receipt/ bill. I can only assure confidentiality for my processing of your charge. I cannot be responsible for any actions taken by your credit card company or any other aspects associated with credit card use.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account: _____ Date: ___/___/____

Missed Appointments, Late Cancellations, and Cancellation Policy

I am acknowledging my understanding that my appointment time has been set aside exclusively for me, and that I am responsible for notifying Dr. Pechenik 24 hours in advance if I need to cancel my appointment.

I am aware that my insurance company will not pay for missed appointments and the fee charged will be the patient's responsibility.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate that would have been reimbursed should the payment been kept as scheduled.

Client's Signature _____ Date _____

Parent/Guardian's Signature_____ Date_____

HIPAA Information Acknowledgement

I acknowledge that I have received the Notice of Privacy Practices Notice. This notice describes how protected health information (PHI) may be used and disclosed.

Client's Signature _____ Date _____

Parent/Guardian's Signature_____ Date_____