Dr. Lea Lockwood
35 South County Commons Way
Suite D-10
Wakefield, RI 02879
(401) 497-4848

FEE AGREEMENT

Standard rates for services have been established. These rates are available upon request and will be reviewed with the client at the initial consultation. The following is a description of the rights and obligations of the parties relative to payment for services.

When health insurance benefits are available for services provided and there is a contract with such insurer, then said insurer will be billed for services. When there is a co-pay required or a deductible must be satisfied, or the services are not covered by insurance, then it is the obligation of the client to pay for the services directly, at the time of services rendered.

It is the responsibility of the client to communicate with their insurance provider relative to any pre-authorization required or on limitations of coverage. If the insurance provider refuses to pay for the services because the client did not comply with the requirements of the insurance provider, then it is the obligation of the client to pay directly upon the receipt of the bill.

If the insurance provider terminates authorization for services, then it is the obligation of the client to pay for services at the regular hourly rate.

All sessions are fifty (50) minutes for intake and therapy; testing sessions are variable (1-6 hours).

Any additional work required to be performed (e.g., court reports or appearances, school reports, on-site visits etc.) are billable at the same rate as therapy.

A $100.00 fee will be charged for any appointment not cancelled within a 24 hour period prior to scheduled appointment time. A $100.00 fee will also be charged to the client for any appointment in which they fail to appear. These fees cannot be charged to the third party providers and will be billed directly to the client.

The undersigned understands and accepts all obligations contained herein.

_____ _____

Signature of Client (parent/guardian) Date

The undersigned understands client is responsible for all neuro/psychological testing not covered by health insurance.

_____ _____ _____

Initials (parent/guardian) Dr. Lea Lockwood, Ph.D, LICSW

IF NEEDED: The undersigned understands client is responsible for educational testing fee (standard rate: $1200.00).

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Initials (parent/guardian) Dr. Lea Lockwood, Ph.D, LICSW