***Life Quality Resources – Service Contract* Authorization for Psychological Evaluation and/or Psychological/Psychiatric Nurse Practitioner Services**

# Service Description:

Life Quality Resources provides psychological evaluations, psychotherapy, cognitive/behavioral therapy, stress management, pain management, psychophysiologic therapy including biofeedback/neurofeedback,

and psychopharmacology.

# Service Fee:

Fees are based on clinical hours and services spent with or on behalf of patients and can include psychotherapy, and/or medication management. Fee structure can include report writing time, time spent

with case managers, and the costs of materials used in the case of psychological testing. Pre-payment is

required for psychological evaluations and new patient intake appointments. Fees accrued following the initial visit will be billed to the designated insurance adjuster and are subject to the terms outlined below. Fees are as follows and are subject to change without notice:

90791 - $220 - $1200 (depending on complexity of evaluation, +90785)

90837 - $150

90876 - $150

90838 - $165

90836 - $150

90833 - $100

90880 - $450

# Terms:

1. Payment is due 30 days from the Invoice Date.
2. Interest will accrue on outstanding balances at a rate of 1 ½% per month.
3. Evaluations must be cancelled 48 hours in advance and therapy sessions/appointments must be cancelled 24 hours in advance to avoid assessment of full fee that would have been charged for the appointment.
4. No shows or cancellations made in less than 48 or 24 hours (as per above) will be subject to

entire fee.

*The North Carolina Industrial Commission (NCIC) considers this service a “pay per your agreement” and is therefore not subject to NCIC fee reduction. Under these terms, the NCIC permits billing for no*

*show/cancellation fees. Furthermore, this contract overrides any previous agreement and/or PPO*

*contract in regards to fee reduction.*

## I hereby authorize Life Quality Resources to perform and provide the services as indicated for the patient named below. I agree fully to the terms outlined herein.

**Service(s) approved:**

**Approved by: (Print Name) Date (Signature)**

**Phone: FAX:**

**Patient’s Name: Date of Birth:**

**City, State, Zip: Phone:**

**Patient’s SS#: Claim #**

**Insurance Billing Name/Address:**

**Insurance Phone: FAX:**

**Urgent: FAX to Life Quality Resources: 919-784-0089**

*Life Quality Resources 5613 Duraleigh Road Suite 101 Raleigh, North Carolina 27612 919-782-4597 919-784-0089 (fax)*