



Sovereign Health of California (SHoCA)  
209 Avenida Fabricante, Suite #100, San Clemente, California 92672  
Tel. 949.369.1300 Fax 949.498.2619

### **PATIENT SERVICES AGREEMENT**

The following patient services agreement outlines Sovereign Health of California's professional fees and financial policy. Fees for service are due the same day of service. Please read carefully and consult with a Sovereign Health of California staff member should you have any questions or concerns.

#### **Financial Agreement:**

I fully understand and agree to the following:

1. I am fully responsible for all fees in connection with professional services rendered to me or my minor child/dependent by Sovereign Health of California. **Patients are expected to pay for each session at the time it is held.**
2. I am fully responsible for all missed appointments or cancellations with less than 24 hours advance notice. A fee equal to the charge for the session scheduled will be charged for each such missed/canceled appointment. **Please note, that insurance companies do not provide reimbursement for missed or cancelled appointments.**
3. My account is due and fully payable at each session.
4. Delinquent accounts (those not fully paid within 30 days of date of service or presentation of the first statement/bill) will be subject to a finance charge of 1.5 percent per month or 18.0 percent per year, unless other arrangements are made in writing.
5. If my account is referred for collection through legal channels, I will be responsible for all reasonable court costs and attorney/collection agency fees in connection with such action.
6. I authorize Sovereign Health of California, director of neuropsychological services and office staff to disclose information about my illness/condition to my insurance carrier for the purpose of processing my claim. This information may include data about my history, diagnosis, and examination findings.
7. I understand that I have been referred to Sovereign Health of California for neuropsychological/psychological evaluation and/or psychotherapy by my physician, psychologist, attorney, therapist, or counselor. The purpose of these procedures has been explained to me and I agree to participate in them.

8. I have been advised of the costs involved with these procedures and agree to them. The costs are as follows:
- A. Neuropsychological/psychological testing (test administration): \$200.00 per hour.
    - a. Specifically for psychological and neuropsychological report writing, a retainer of \$600.00 is due prior to the scoring and report writing commencement.
  - B. Scoring/interpretation of neuropsychological/psychological test data: \$200.00 per hour.
  - C. Report to referring professional summarizing history and examination/test findings: \$200.00 per hour.
  - D. Review of medical/academic/legal records: \$250.00 per hour.
  - E. Telephone consultation to my attorney: \$295.00 per hour.
  - F. Meeting with my attorney: \$295.00 per hour.
  - G. Testimony as an expert witness on my behalf: half-day: \$2,000.00; full-day: \$4,000.00.
  - H. Initial consultation: \$200.00 per 60-minute session.
  - I. Individual psychotherapy: \$200.00 per 50-minute session.
  - J. Family psychotherapy: \$250.00 per 75-minute session.
  - K. Group psychotherapy: \$150.00 per 90 minutes.
  - L. Bounced checks: \$20.00 per check.

**Insurance Reimbursement:**

Sovereign Health of California is not a preferred provider for insurance companies and therefore we do not accept insurance as direct payment. Sovereign Health of California will provide an invoice itemizing services rendered that may be submitted to my insurance carrier for review of reimbursement. We do this as a courtesy to our patients. Please note patients are **fully responsible for full payment of services rendered by Sovereign Health of California.**

**MY SIGNATURE BELOW INDICATES THAT I HAVE READ PAGE 1 AND PAGE 2 OF THIS PATIENT SERVICES AGREEMENT AND AGREE TO THE TERMS.**

\_\_\_\_\_  
 (Signature of patient or patient's Legal Representative)

Date: \_\_\_\_\_

\_\_\_\_\_  
 Printed Name

\_\_\_\_\_  
 (if signed by someone other than the patient, state your relationship to the patient)