Dr. Ernest Reilly, LCSW • 1631 Hillcrest Street, Orlando, FL 32803 • (407) 843-4968

ADHD/ ADD Procedures and Payment Policies 2023

Please read the following ADHD/ADD testing procedures policies that will apply to administrative operations, as well as policies related to private payment and payment by insurance companies and managed health care.

- Testing varies, it is typically $250 depending on the how extensive the testing is; however, pricing will be discussed at the initial Diagnostic Interview session. Insurance may or may not pay any, a portion, or all the expense involved.
- Testing Sessions often vary in length from 20-60 minutes, most sessions are typically 40-80 minutes including time for paperwork. For children, ages ranging from 6- 17 years old, the testing sessions will consist of **three different sessions** which are the Diagnostic Interview, the Testing Session, and the Results session. For adults, 18 years old and beyond, testing sessions will consist **of two different sessions**. For adults, the first session will combine the Diagnostic Session and the testing. The second session will be the Results session. While this is the general format, changing the procedures is depended upon individual circumstances and at the discretion of the provider.
- The testing results may be **available 7-10 business days** after the return and completion of all testing materials. During the Results Session per the procedures, the provider will discuss the results and answer any questions. Upon request, a copy of results will be provided. Results will not be disclosed to others unless there is a **Release of Information** signed ahead of time. We acknowledge that testing and results can be a lengthy process. We appreciate your patience and assistance in making it a smooth process.
- I fully understand and accept that regardless of my method of payment for services, I am fully responsible for the timely payment for services rendered.
- Please understand that we file insurance as a courtesy to our patients. If you choose to have our office file for your insurance, all insurance information **MUST** be presented prior to your session. Our office will not backdate any claims. Please bring your insurance cards with you and be aware of your insurance contract information. Your insurance benefits, deductibles, copays, and coverage are not determined by our office. We can only assist you in estimating your portion of the cost of treatment**.** **YOU** are responsible for unpaid balances due to a lack of information or for services provided but not covered by your plan.
- If you choose to have our office file your insurance, you accept our assistance in managing claims, while you maintain **FULL** responsibility for all unpaid claims. We will file claims by mail or electronically on a regular basis; therefore, we will not be responsible for delays and denials. It will be your responsibility to ensure we receive prompt payment from your insurance company. We will re-file unpaid claims (usually every 45 days). A $25 filing fee may be charged per re-filing if deemed excessive.
- Our office expects that all deductibles, co-payments, co-insurance, or fees not covered by your insurance carrier will be paid **at the time services are rendered**. Although we will verify your insurance as a courtesy to you, it is your responsibility to be aware of insurance coverage limits, and we encourage you to monitor the number and type of services approved. PLEASE remember that any benefits quoted by your insurance company are ***NOT a Guarantee*** of payment. Our office will bill only one responsible party. It is your responsibility to arrange payment at the time services are rendered.
- You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Disclaimer: We do NOT provide medication, nor do we write prescriptions.
Upon request, psychiatrists may be recommended.

Thank you for allowing us the opportunity to serve you and your family.

By signing I acknowledge that I understand the above policies and agree to them.

Patient Name: ____

Patient/Parent Signature: ___________________________________ Date: _____________

Address: ____ Phone: ______________________