Scott Conkright PsyD

P S Y C H O L O G I S T

Office Procedures and Patient Contract

The 45-minute Hour

Individual, Coaching and Couple Sessions last forty-five minutes.

Group session lengths are 75 minutes long.

Fees

Individual	:	$275
Couples	:	$275
Group	:	$110

I can arrange a lower fee for a limited period of financial hardship.

Billing

Fees are paid at the end of each session. I accept checks, cash, and Venmo. My preferred electronic payment is Zelle, which you should be able to do through your bank. If you will use a check, I prefer that you have this made out before the session.

You are responsible for billing your insurance unless arrangements have been made with me. I will provide you with the necessary paperwork to do so. No matter what form of payment you are using, you are fully responsible for any balance for therapy charges (including missed or canceled sessions)

Cancellations and Missed Appointments

If you need to cancel or reschedule an appointment, please do so with 48 hours' notice. This allows me to offer that hour to someone else. If you do not attend your appointment or cancel or reschedule without 48 hours' notice, you will be charged the full fee for that hour. As a general policy, most insurance and managed health care providers do not reimburse for missed or canceled sessions. Nor do they usually allow you to apply the charge toward your deductible or co-pay.

Psychological Emergencies

If you are experiencing a medical emergency, please dial 911 or go to the nearest emergency room. If you have an urgent message for me, leave a voicemail message. Messages are checked every few hours; expect it to take this long (or longer). I will return your call immediately, but never after 24 hours. Late-night messages are not likely to be returned until the following morning.

Vacation and Calls

Billing phone calls over ten minutes is prorated according to hourly fees.

Agreement

I, _____ , agree to the terms and conditions of these office
(Patient's Full Name)
procedures and patient contract .

Patient's Signature _____ Date _____