Powers Ferry Psychological Associates, L.L.C.

The Offices of:

Gerald S. Drose, Ph.D.
Dina M. Zeckhausen, Ph.D.
Steven Perlow, Ph.D.
David M. Schwartz, Ph.D., ABPdN
Abby L. Friedman, Ph.D.
Kimberly Smiley, Psy.D.
Jennifer Spring, Ph.D.

And the Offices of:

Martin Fleet, Ph.D.
Susan Berel, Ph.D.
Elaine Eassa, Ph.D.
Keith Helmken, LCSW
Jennifer Swales, Ph.D.
Rachel Seinfield, Ph.D.
Brian Smith, Psy.D.
Katherine Higgins, Ph.D.

PAYMENT FOR SERVICES AGREEMENT

Provider/Supplier Notice to Beneficiary Regarding Service(s) That May Be Denied Payment by Your Insurance Carrier as "Not Reasonable and Necessary"

Notice to Beneficiary:

Your insurance company: _____ may only pay for services that ***it*** determines to be ***"reasonable and necessary"*** under their contract with you/the enrolled individual and Dr. Schwartz. If your insurance company determines that a particular service, is *"not reasonable and necessary"* or viewed as a *"not-covered service"* or the evaluation leads to diagnosis that is not covered, your insurance company may deny payment for that service.

You, alone, are responsible for payment of services and the insurance company may or may not reimburse you.

By signing this Agreement, I acknowledge that I have been made aware of Dr. Schwartz' Payment for Services Agreement and agree to abide by it. I also agree that his office can provide any requested medical, psychological and/or neuropsychological information to my carrier, or its agents, if required for determination or payment of benefits.

I am eligible for coverage under more than one health insurance policy (please circle): Yes No

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

Client signature_____ **Date**_____

Guarantor (if different)_____ **Date**_____

Witness_____ **Date**_____