Spader Psychological Services, LLC

Michelle Spader-Cloud, PSYD, BCBA-D, COBA

Licensed Clinical Psychologist • Board Certified Behavior Analyst • Central Ohio Behavior Analyst
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PRIVATE PAY AGREEMENT

Name of Patient: _____

If applicable, Name of Parent/Legal Guardian: _____

I, _____ (print name of person responsible for payment), by signing this agreement, indicate that I understand that my or my child's treatment with Dr. Michelle Spader-Cloud beginning _____ (date) will not be covered by insurance because (please initial one below):

_____ I do not have insurance coverage for the services I am seeking. This may be because I do not have any insurance coverage, or that the service is not (or no longer) a covered benefit under my insurance plan and/or it does not meet the plan's standards for medical necessity.
_____ Dr. Spader-Cloud is not in-network with my insurance plan.
_____ I am choosing not to use my insurance coverage for Dr. Spader-Cloud's services.
_____ If non-coverage is the result of a decision by my insurance plan, I have been informed about the reason, am aware of my plan's formal appeal process, have elected not to appeal, or am in the process of appealing. In the meantime/instead, I elected to continue receiving services on a self-pay basis, and I understand I will not be reimbursed by my insurance unless I am successful on appeal.

Other (please initial all):
_____ I agree that Dr. Spader-Cloud may collect charges for the services at her full fee-for-service rates.
_____ I understand that Dr. Spader-Cloud will collect payment for the evaluation at the end of the evaluation feedback appointment (or at the end of each therapy visit if this is the service I am receiving).
_____ I understand that Dr. Spader-Cloud will not be submitting a bill to my insurance and that my private payment for Dr. Spader-Cloud 's services will not factor into my insurance plan's maximums (e.g., deductible).
_____ I understand that in not using insurance for these services, I waive any future right to bill insurance or be reimbursed by an insurance plan for sessions that have already taken place.
_____ If I have insurance coverage and am choosing not to use it, I am aware that there may be other providers who are in network with my insurance company, and that if I were to see those providers, some/all of my bill could be covered by insurance benefits (mark n/a if you do not have any insurance coverage).
_____ I understand that this consent is subject to revocation at any time except to the extent that action has been already taken in reliance thereon.

_____ _____
Signature of Patient (or parent/guardian) Date Relationship to Patient (if necessary)

_____
Michelle Spader-Cloud, PsyD, BCBA-D Date

Revised 4/6/22