
Sidney W. Binks III, Ph.D.

Neuropsychologist/Clinical Psychologist

Neuropsychological Assessment
Psychoeducation Assessment
Forensic Assessment

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Individual/Couples Psychotherapy
Multi-Cultural Identity
HIV Issues

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PATIENT AGREEMENT

I, the undersigned, realize that I am financially responsible for all services rendered to me by the practice of Sidney Binks, Ph.D. (herein referred to as "The Practice"). In the event of nonpayment of my account within sixty (60) days after an invoice is rendered, I agree to pay interest at the rate of 1 percent (12 percent per year) on the unpaid balance until the account is paid in full. If the account is delinquent, and if the account is referred for collection, I agree to pay all expenses incurred in collecting the same, including without limitation, a reasonable attorney's fee equal to 50 percent of the amount owed at the time the account is referred, and all court costs.

For those insurance plans for which The Practice accepts assignment, I realize that I am personally responsible for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage. For those insurance plans for which The Practice *does not* accept assignment, I realize that I am responsible for 100 percent of all charges which may include fee rates which are above what my insurance coverage may term "usual and customary." I also authorize the Practice to release to my insurance carrier(s) any clinical or treatment information necessary to obtain reimbursement. I authorize any and all insurance payments be made directly to the Practice for all rendered services. I permit a copy of this authorization to be used in place of the original.

Appointments that are not kept, and are not cancelled with 24 hours notice will be charged at the rate per hour for the service. If this cost is not covered by the insurance company, I understand that I am responsible for it. The exception to this rule is when there is inclement weather and DC schools are closed, or if there is a medical emergency on the part of the patient or his/her dependent.

Print Name of Patient

Guardian (if Applicable)

Signature(s)

Date