**Advanced Counseling and Testing Solutions, LLC**

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# Psychological Testing Agreement

Psychologist:_____

- By signing below, I understand that I am responsible for timely payment of services rendered by Advanced Counseling and Testing Solutions, LLC not covered by insurance.
- I understand that half of the testing fee (i.e. deductibles, out-of-pocket) is due at the time of the first testing appointment and the remaining is due prior to the receipt of the psychological evaluation report.
- I understand that I will not receive the written results of the evaluation until all testing is paid for in full.
- I understand that ACTS cannot and will not bill a third party insurance company for any testing that will be used for educational purposes by law. Please refer to your commercial insurance policy regarding these stipulations.
- We do our best to attempt to confirm all insurance coverages prior to your initial visit. As per all insurance carriers, “It is the patient's responsibility to ensure that the practice and/or clinician you are seeing is in-network with your carrier and benefit information given over the phone (or portal) is not a guarantee of payment until each claim is processed.”

_____
Patient Name (please print)

_____
Parent or Legal Guardian (please print)

_____ _____
Patient, Parent or Legal Guardian Signature Date

*Helping clients is our mission, not only our profession!*