Beacon Pediatric
BEHAVIORAL HEALTH

PSYCHOLOGICAL ASSESSMENT/ TESTING AGREEMENT

This document explains the process and policies for psychological testing at Beacon Pediatric Behavioral Health. **It is very important that you read this document fully and carefully and ask any questions you may have.** Please also ensure that you have reviewed all other documents that you signed at the initial intake, as they provide more detailed information about other related policies (copies can be found at **www.beaconpediatric.com** as well). Please INITIAL at the end of each page to attest that you have read, understand, and agree to the information presented; please also sign and provide any requested information at the end of the document.

ASSESSMENT STEPS

- **Initial Intake**
  - First appointment; provider gathers information from client and parent/guardian through an interview about background history, current concerns, symptom presentation, etc.
  - At the conclusion of this appointment, the evaluator will determine which measures may be most appropriate for your evaluation needs and the testing appointment(s) will be scheduled with the client (except on a rare occasion when the testing appointment has already been scheduled to occur immediately after the intake)
- **Pre-authorization**
  - Some insurance plans require pre-authorization, which cannot be submitted until the evaluator gathers the necessary information during the intake interview.
  - If your plan requires pre-authorization, the evaluator will submit the necessary information to insurance within a week of your initial intake. Testing cannot be scheduled until insurance approves it and provides an authorization number; the amount of time for response by insurance may vary, though typically takes between 1to 4 weeks.
- **Direct Testing**
  - Evaluator administers psychological test directly to client, makes observations, gathers information from parents/guardians and teachers (where relevant), reviews records, etc.
  - Assessment may include: IQ test, developmental assessment, neuro-psych batteries, ADOS-2 (Autism test), self-report measures, parent/teacher questionnaires, symptoms specific rating scales, etc.
  - Client/child (and parent/teacher where relevant) is present and/or participatory during this portion of the assessment.
  - Testing is scheduled in 1.5-2 hour blocks and may take between 1 to 3 days to complete.
- **Indirect Assessment Tasks**
  - Evaluator scores, measures, interprets test results and analyzes clinical data, performs clinical decision making, makes diagnostic conclusions, and/or integrates and summarizes information.
  - Client/child/parent/teacher are NOT present nor participatory during this portion of the assessment.
  - This portion of the assessment is typically performed *on a different date(s) after the date* of 'face-to-face' testing (and as such, will show up as an additional date on your insurance EOB and/or bill; as such, ***a separate/additional co-pay may apply***
- **Consultation/Review of Results**
  - Evaluator meets with parents/guardians in person or virtually and explains client's obtained scores, discusses diagnostic conclusions, and reviews clinical recommendations.
  - No specific guarantees are made about the results of the evaluation (including diagnoses).
  - Consultation will typically be scheduled approximately 2-3 weeks after the final part of the assessment is completed and/or after all questionnaires/measures have been returned to the evaluator.
  - Evaluator may provide parents/guardians a copy of the official report during this appointment or may provide a draft summary of scores during this appointment and later send parents/guardians the final official report. We will not share the report with anyone; you may share copies with whomever you wish, at your discretion.

USING INSURANCE FOR PSYCHOLOGICAL TESTING SERVICES

Clients are responsible for confirming their coverage and benefits prior to services, as clients are ultimately responsible for payment of any costs not reimbursed by insurance. ***Clients should contact insurance prior to testing with the following questions***:

- Does my plan cover behavioral health services, including testing? (CPT codes include [but not limited to]: Intake 90791, Testing 96130, 96131, 96136, 96137, Consultation/Therapy 90837, 90834, 90832, 90847, 90846)
- Does my plan cover the diagnosis(es) that testing is needed for? (Common ICD-10 codes include [but not limited to]: F84.0 (Autism), F91.9 (Disruptive Disorder), F91.3 (ODD), F90.2 (ADHD), F41.9 (Anxiety), F43.20 (Adjustment Disorder), F81.0, F81.2, F81.81 (Learning Disorders)
- Does my plan require pre-authorization for psychological testing (the CPT codes above)? If yes, what must be done, by whom, and if a form is required, where can this be found?
- What patient responsibility is associated with psychological testing services? (copay, co-insurance, deductible [how much remains?])
- Is Beacon covered under my insurance for psychological testing? (***Provider:*** Beacon Pediatric Behavioral Health, ***Group NPI***: 1770838872, ***Directors:*** Adrienne L. DeSantis King, Ph.D., BCBA-D, licensed psychologist/Board Certified Behavior Analyst, Doctoral, (NPI: 1467605493), Parastoo Nabizadeh, Psy.D., BCBA-D, licensed psychologist/ Board Certified Behavior Analyst, Doctoral (NPI: 1114226974), ***Primary Address:*** 6816 Southpoint Pkwy, Ste 202, Jacksonville, FL 32216)

OFFICIAL DIAGNOSTIC REPORT

During the consultation session, evaluator may provide parents/guardians a copy of the official report (if written report has been completed and entire balance has been paid) or a draft summary of scores may be provided, with the official report sent at a later time, once report is fully completed and balance paid. For clients using insurance, claims may take several weeks to process, which may delay completion of the final official report. In such circumstances, Beacon reserves the right to estimate charges (co-pay, co-insurance, etc.) and require client payment prior to receipt of the EOB to facilitate the completion and provision of the final report. For clients with a deductible, you will be required to pay an estimated total prior to starting testing (please see the ***Financial Agreement***).

FEES

Cost for testing will vary SIGNIFICANTLY depending on the type of assessment you are seeking, the reimbursing entity ('self-pay' vs. health insurance [each plan will vary as well]), the amount of time and number of units required to complete all parts of the assessment, the 'allowed amount' that your insurance has agreed to for testing CPT codes, and the details of your insurance plan (e.g., service or diagnosis exclusions, co-pay, cost-share, deductible, and/or yearly cap amounts). Under insurance, even the 'allowed amount' for different service CPT codes may vary dramatically across different plans, and rates are typically changed by insurance annually. Clients must review, complete, and sign the ***Agreement for Behavioral Health Services***, the ***Financial Agreement***, and the ***Authorization for Credit Card Charges*** form. Details regarding potential estimated fees and payment expectations are explained within the documents listed above, as well as within the ***Estimate of Fees*** document that can be provided to you upon request.

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Beacon reserves the right to estimate fees and charge client prior to testing and/or provision of the final report under the following circumstances: if an insurance benefit evaluation reveals that a deductible remains or that the cap has not been met and co-pays apply, if Beacon is unable to clearly determine patient responsibility via the insurance portal ahead of time, if claims have been submitted to insurance yet no EOB has been provided to Beacon within 2 to 4 weeks of claim, and/or if patient has displayed a pattern of delinquency in payment for previous charges. Once your insurance processes the claim and provides Beacon with the EOB, Beacon will refund the client's credit card any overage paid, or if client has underpaid, Beacon will charge the client's credit card on file the difference in cost. If you have a high-deductible plan, you will be responsible for the entire insurance-contracted rate, which may range between $500.00 and $1800.00. If academic testing is required and not covered by insurance, and/or for gifted testing, client MUST pay this self-pay fee ($500.00) prior to testing and/or release of official report.

DETAILS ON COVERAGE AND POTENTIAL COST ARE PROVIDED BELOW BASED ON A BENEFIT CHECK CONDUCTED ON _____.
DETAILS SUBJECT TO CHANGE IF BENEFITS CHANGE OR IF THE FISCAL YEAR RESTARTS AFTER THE TIME OF THIS ESTIMATE.

INDIVIDUAL/FAMILY *OOP MAX* REMAINING AS OF THIS DATE:		
INDIVIDUAL/FAMILY *DEDUCTIBLE* REMAINING AS OF THIS DATE:		
Anticipated ESTIMATE for COPAY/CO-INSURANCE due		
Anticipated GENERAL ESTIMATE for INITIAL INTAKE INTERVIEW		
Anticipated GENERAL ESTIMATE for TESTING (Direct, Indirect, & Feedback Consultation)		
Anticipated GENERAL ESTIMATE for TOTAL 'PATIENT RESPONSIBILITY' due under insurance		
Anticipated 'SELF PAY' TESTING (e.g., academics, gifted, etc. not covered by insurance) amount due (does NOT apply towards insurance or deductible)		
TOTAL ESTIMATED AMOUNT TO BE PAID PRIOR TO TESTING: ***(This is NOT a guarantee. Insurance may process claims differently than benefits show. Insurance claims may reflect patient responsibility for TESTING for as much as $1800.00, not including self-pay costs)***		

I have reviewed and understand the information above and on the Client Agreement for Behavioral Health Services, the Financial Agreement, and the Authorization for Credit Card Charges form (as well as the Estimate of Fees document, if requested). My signature below indicates that I am seeking testing services for my child and understand the potential costs involved with the services I am seeking, whether 'self-pay' or using insurance. Further, I authorize and request Beacon Pediatric Behavioral Health ("Beacon") to charge my card(s) indicated below and/or as listed on the Credit Card Authorization Form, prior to services being rendered or immediately thereafter, for the estimated amount due listed on this Testing Agreement. I understand that the card(s) will be charged in accordance with the Agreement for Behavioral Health Services, the Financial Agreement, and the Credit Card Authorization Form as well. Further, I acknowledge my financial responsibility and agree to pay all costs that are determined to be 'patient responsibility' under insurance, or self-pay I understand that the information provided related to potential cost for insurance clients is a general estimate of costs and NOT a guarantee of exact cost, and that amounts are subject to change. I also attest that I am aware of my insurance coverage and benefits as they relate to psychological testing. I am aware that I will owe Beacon for any amount due to be considered as counting towards my plan's deductible, and I am responsible for payment of any additional amount determined to be 'patient responsibility' by insurance after the claim has processed, if more than the amount above. I agree that I am responsible for any balances due and I understand that failure to pay my balance within the required timeline will result in Beacon pursuing the steps outlined within the 'Delinquent Accounts' section of the Agreement for Behavioral Health Services and the Financial Agreement that I have signed. This authorization will remain in effect unless I choose to cancel the authorization by providing a 60-day notification in writing after my account is in 'good standing' ($0 balance; account is not delinquent, etc.). I attest that I am designated as the financial guarantor and will be ultimately responsible for payment of any balances due, understanding the ramifications if left fully or partially unpaid.

Client Name: **Your Name ("Guarantor"):**

Insurance ID: **Email Address:**

Your Social Security Number (REQUIRED): | | | | | | | | | |

Signature: **Date:**

PRIMARY CARD FOR CHARGES:

	Credit Card		**Debit Card***		**HSA/FSA/Flex***
	Visa		**Mastercard**		**Discover**
CREDIT CARD NUMBER:				**EXPIRATION DATE:**	
CARDHOLDER'S NAME:				**CODE ON CARD:**	
BILLLING ADDRESS:					

***SECONDARY CARD FOR CHARGES (ONLY REQUIRED IF PRIMARY CARD IS NOT A 'TRUE' CREDIT CARD)**

	Visa		**Mastercard**		**Discover**
CREDIT CARD NUMBER:				**EXPIRATION DATE:**	
CARDHOLDER'S NAME:				**CODE ON CARD:**	
BILLLING ADDRESS:					