

## Financial Policies of Linda Santoro, RN, Ph.D., LLC

### Fee and payment information

Payment can be made with either cash, check, or credit card. Checks may be made payable to: Linda Santoro, RN, Ph.D., LLC. Payment is to be made in full at each session unless other arrangements have been made. There is a \$15 fee for returned checks.

### Insurance

If you are using insurance to pay for any part of your therapy, I may be required to release information about you to your insurance company. This may include, but is not limited to: symptoms, diagnoses, treatment plan, and progress toward goals. Please discuss this with me if you have any concerns about what I would share.

For most insurance plans, I am considered an *out-of-network* provider. When checking your coverage, it is best to confirm the following for what is usually called “Mental Health” or “Behavioral Health” coverage:

- (a) The amount of your deductible,
- (b) The percentage of the cost per session covered;
- (c) What your company considers “reasonable and customary” fees for the services I provide (code “90791 – Diagnostic Evaluation” which is our initial appointment and code “90834 – Psychotherapy” which are our on-going appointments); and
- (d) What you should expect to pay as your copayment.

### Missed appointments and cancellations

If you need to cancel or reschedule an appointment, I would appreciate as much advance notice as possible. Please note, cancellations **must be made 24 hours in advance** of your appointment to avoid being charged the full fee (not just the co-payment) for a missed session. Insurance companies do not reimburse for missed or late-canceled sessions. I ask that payment for missed appointments be made at the next scheduled session. There are various reasons for this policy, most importantly is that I have set aside specific time to focus on your concerns. That time is dedicated to our work together and I make every effort to let nothing interfere. I ask for your mutual respect by giving me 24 hours in advance to allow me to adjust my schedule accordingly if you cannot come in.

Your signature below indicates that you have read and understand the financial policies of my practice. . If you have any questions, please do not hesitate to ask.

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Signature

Date