

Amy Boyers, Ph.D.  
Licensed Psychologist  
7325 SW 63<sup>rd</sup> Avenue, Suite 101  
South Miami, FL 33143  
786-235-9000 (phone) / 305-667-9880 (fax)

### THIRD PARTY PAYOR AGREEMENT

I/We, \_\_\_\_\_, agree to pay Dr. Amy Boyers for psychological services rendered to \_\_\_\_\_. I understand that Dr. Boyers's fee is \$165 before 5:00 pm or \$185 after 5:00 pm per hour and have read over the business policies and billing practices outlined in the informed consent.

We elect the billing arrangement below as indicated by our initials:

\_\_\_\_\_ I/We will bring payment to each session with Dr. Boyers.

\_\_\_\_\_ I/We will mail payment within 5 business days of receiving an invoice from Dr. Boyers.

\_\_\_\_\_ I/We will provide payment at the beginning of the month for all sessions expected in that month. Any unused sessions will be credited toward the next month.

\_\_\_\_\_ I have provided my credit card information which will be kept on file and charged at the time of the session.

Although Dr. Boyers will fill out forms and provide reasonable assistance, as needed, in helping me receive the benefits to which I am entitled through my insurance, I understand that I (not my insurance company) am responsible for full payment of these fees.

I understand that if my account has not been paid for more than 60 days and alternative arrangements for payment have not been agreed upon, Dr. Boyers has the option of using legal means to secure the payment. This may involve hiring a collection agency or pursuing a claim in a court of competent jurisdiction (e.g. small claims or other court). If such legal action is necessary, I understand that I will be responsible for the costs Dr. Boyers incurs in said process. In most collection situations, the only information released regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date