Michelle L. Hobby, Ph.D.
Licensed Psychologist, PSY 21171
9666 Businesspark Ave., Suite 202, San Diego, CA 92131 ~ (858) 414-2523

Financial agreement

First, Middle, Last Name: ____

Social Security Number: ____________________ Date Of Birth: ____________________

Insurance Information (please provide a copy of your insurance card- front/back)

Primary Insurance Company (name, address, phone number):
____
____
____

Policy & Group Number: ______________________________
Name & birth-date of primary insurance subscriber: ______________________________
Employer name ______________________________________

Credit Card Information ***This information is required as a guarantee of payment. Your card will not be charged without your authorization.*

Type of Card (Visa, Mastercard, etc): ____________ Cardholder's Name: ________________
Credit Card Number: ______________________________________
Expiration Date: __________
Security Code (3 or 4 digits on back/front of card): __________
Billing zip code _________

* Credit cards are accepted for session payments
The following transaction fees apply $1.00 ($99-under), $2.50 ($100-over), $3.75 (for "card not present" or paypal payments).

If making payments by check, please pay to the order of Michelle Hobby, Ph.D.

Standard Fees: Initial Assessment & Ongoing Treatment, 45-50 minutes: $100-200 **Group Therapy:** $20-40
Phone Calls: over 10 mins., charged at hourly rate **Court Fees:** $400/Hr

By signing below, I agree to pay a fee of $_____ per individual session, and $_____ per family/couples session to Michelle Hobby, Ph.D., for services provided. Having your payment ready at the beginning of the session allows for full use of your session time.
I understand that this fee is subject to change, and any change in fee will be as mutually agreed upon. I understand that my fee is subject to periodic review, particularly if I am paying a reduced fee and my financial situation changes. I agree to pay for services at the time they are provided. I understand that, if I do not pay for my services within 30 days of the date of service, my fees plus credit card transaction fees will be charged to my credit card listed above.

If I am utilizing my health insurance to pay for these services, I hereby assign any payments from my health insurance provider to Michelle L Hobby, Ph.D. By signing below, I hereby authorize the release of any medical information needed by my insurance provider to process claims submitted for payment. I agree to be responsible for any charges not covered by my health insurance.
I understand that my health insurance cannot be billed for missed appointments.
My co-pay is $________ per session, and due at the time of service
I agree to pay the full fee for appointments canceled or missed <u>without</u> providing 24hr notice prior to the scheduled appointment

Signature: ______________________________ Date: ____________