Ildiko Tabori, PhD

Psychologist

CA PSY19688

Financial Agreement

I fully understand and agree to the following terms:

1. I am fully responsible for all fees in connection with professional services rendered to me or my minor child/dependent by Ildiko Tabori, PhD, a licensed psychologist.
2. I am fully responsible for all missed appointments or cancellations with less than 24 hours advanced notice. A fee of **$80** for the session scheduled will be charged for each such missed/cancelled appointment.
3. My account is due and fully payable within 30 days of service unless other arrangements are made in writing.
4. Delinquent accounts (those not fully paid within 90 days of date of service or presentation of the first statement/bill) will be subject to a finance charge of 1.5% per month or 18% (or the maximum interest rate allowed by law) per year unless other arrangements are made in writing.
5. If my account is referred for collection through legal channels, I will be responsible for all reasonable court costs and attorney/collection agency fees in connection with such action.
6. If health insurance is involved, the Office of Ildiko Tabori, PhD will bill my insurance carrier only as a courtesy to me. I am still fully responsible for all fees and charges that my insurance carrier does not cover or pay.
7. I authorize the Office of Ildiko Tabori, PhD to disclose information about my condition to my insurance carrier for the purpose of my claim. This information may include information about my history, diagnosis, and examination findings. I authorize direct payment of insurance benefits to Ildiko Tabori, PhD by my insurance carrier.

I have read all of the above terms carefully, understand them, and agree to them.

Signature: _____ Date: _____

Name (please print): _____