LINDNER
CENTER OF HOPE

4075 Old Western Row Road
Mason, Ohio 45040
(513)536-0537 or 1(888)53-SIBCY (7-4229)
www. lindnercenterofhope.org

PSYCHOLOGICAL TESTING CONTRACT

Lindner Center of Hope (The Center) appreciates the confidence you have shown in choosing us as your treatment care provider. Our patient and family-centered treatment philosophy requires that we openly communicate our policies and expectations about payment for our services before treatment is initiated. Please take a moment to familiarize yourself with this agreement prior to signing.

PAYMENT RESPONSIBILITY:

I acknowledge that I am financially responsible for all charges associated with services provided to the patient named below through the Psychological Testing program. I understand that payment outlined below is due in full prior to admission to the program and full payment prior to the start of additional services. I understand that interruption of a program for a clinically determined medical condition will result in suspension of the program until such time as the patient is cleared to complete the program. At my request, The Center will inform me of their ability to assist me in billing my insurance but will not be responsible for appeal and follow-up on claims. **I acknowledge the psychological testing services are an elective self-pay treatment program. I understand I am financially responsible for the payment of these services.**

PSYCHOLOGICAL TESTING - IN ADDITION TO A WILLIAMS HOUSE OR SIBCY HOUSE CONTRACT:

☐ Psychological Testing $6,000

Start Date _____ End Date _____

SERVICES INCLUDED IN PROGRAM PRICING

Psychological Testing

REFUND POLICY:

All services and program fees are non-refundable.

I fully understand and agree to the above policies and conditions described in this agreement.

Patient's Signature: _____ Date: _____

Person Financially Responsible Name: _____ Signature: _____
(please print)

Address: _____ Date: _____

_____

LCOH Staff Signature/Title: _____ Date/Time: _____