

**SALLY G. HOYLE, PhD
10475 PERRY HWY, SUITE 100
WEXFORD, PA 15090
724.272.2124
FINANCIAL POLICY**

I, _____, understand that I am financially responsible for any and all charges incurred in this office whether or not paid by my insurance carrier.

I hereby assign payments to be made to Sally G. Hoyle, PhD or representatives on my behalf for services provided to me.

PLEASE CHECK ONE OF THE FOLLOWING:

I do not have insurance at this time or it will not cover services in this office.

I have insurance but elect not to use it for these services and will self-pay.
***PLEASE NOTE: Retroactive billing for insurance coverage is not available with this option.**

My insurance carrier will cover _____ sessions. I will be responsible for any remaining balances and co-pays in the amount of: \$_____.

Co payments due on my account will be paid:

At the time of service

Other

I agree to the terms and agreements of this notice.

Signed: _____

Dated: _____

Witness: _____