

FINANCIAL POLICY STATEMENT

The following is our financial policy that I request you read, understand and sign prior to treatment.

Insurance (Our **Insurance Verification Form** helps when speaking with your carrier.) Your insurance policy is between you and your insurance company. I am not party to that contract. If your insurance plan requires authorization for outpatient mental health services, you must obtain this authorization prior to treatment and provide my office with the referral/authorization number, the date range of authorized treatment, and the number of sessions authorized. **If for any reason services are not covered by your insurance policy (i.e. annual maximum benefits exhausted, pre-existing condition clause, etc.), you are responsible for all session fees.** I do accept assignment of benefits from insurance companies with whom I am a participating provider. I will file your insurance claims for you, either by paper or electronically, unless otherwise specified by you.

Payments

All payments, co-pays and/or deductibles are due prior to each session. Additional services will not be provided to clients whose balances exceed \$100. We accept payments in the forms of cash, check or credit card.

Appointment Cancellation Policy

Your appointment time is reserved for you, and it may be necessary to charge for continued missed appointments (No Shows) or for appointments not cancelled with 24-hour notice (Late Cancellations). You, personally, will be held responsible for these charges.

Billing

Payment for all client statements is due in full upon receipt. Payment arrangements can be made in advance for some accounts. Failure to pay your bill will result in your account being turned over to a collection agency. Only your account status will be discussed with the collection agency.

Returned Checks

A \$30 service fee will be added to your account for each returned check from your bank. Only cash payments will be accepted if two NSF checks are received.

My signature below acknowledges that I have read, fully understand and agree to all parts of the financial policy. I also understand that my account may be turned over to a collection agency if it becomes delinquent.

Signature of Client _____ Date _____
Signature of Parent/Guardian _____ Date _____
Witness _____ Date _____