

Office Financial Policy and Billing Agreement

Name (*print*): _____ Soc.Sec. _____

Insurance Coverage:

- ❖ I agree to contact my **Insurance Company to verify the Mental Health benefits**. (You pay for your insurance. It is your responsibility to know the benefits of your policy). _____ *initial*
- ❖ Should a dispute arise on a claim, **it is generally the clients' responsibility to clarify and resolve the dispute with the insurance company**. _____ *initial*
- ❖ If insurance *is* being filed, any deductible not yet met is **due at the time of service**. _____ *initial*
- ❖ I understand any **co-pay is due at the time of service**. If a minor, the person that accompanies the child will pay the co-pay. _____ *initial*

Payment:

- ❖ If Insurance *is not* being filed, **payment is expected at the time of service**. _____ *initial*
- ❖ **I agree to provide a 24-hour notice to cancel an appointment**. A late charge of **\$50.00 may be assessed if notice is not provided**. If you have **Medicaid, this charge does not apply**. _____ *initial*
- ❖ If a client does **not show for a scheduled appointment**, there is a **no-show charge of \$50.00**. If you have **Medicaid, this charge does not apply**. _____ *initial*
- ❖ A service requested by the client, but not covered by the client's Insurance plan, may be arranged under a separate written agreement with the office. _____ *initial*
- ❖ Phone calls are **not** billable to your insurance. Phone calls are **billed for the amount of time spent on the phone, at the hourly rate**. (See fee schedule). _____ *initial*
- ❖ Statements will **NOT** be sent to a third party, without their **written agreement to pay**, on file. _____ *initial*
- ❖ Accounts are **NOT** carried **beyond 90 days**, without payment. I understand my account may be sent to a Collection Agency if it becomes delinquent. _____ *initial*
- ❖ Fees are subject to change at the discretion of the practice. A fee schedule is available upon request. _____ *initial*
- ❖ There is a \$20 administration charge for checks that do not clear the bank. _____ *initial*
- ❖ Questions regarding your account should be directed to the Billing Office at 398-1138. _____ *initial*

I certify that I have read, understand and agree to the foregoing. The undersigned is the client or is duly authorized by or on behalf of the client to execute the above and accept its terms.

Signature of Client or Responsible Party

Date

Signature of Witness

Date