PSYCH AND PSYCH
Diana Santantonio, Ed. S. Associates, LLC

FINANCIAL AGREEMENT

I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family where I am listed as the responsible party. I hereby agree to pay my insurance deductible and/or co-payment as services are provided. If for any reason there is a balance due on my account, I agree to pay promptly upon receipt of the monthly statement. It is also my responsibility to review the Explanation of Benefit (EOB) forms I receive from my insurance so I can track insurance payment for services rendered.

I understand that my insurance claims will be sent electronically via computer modem to the Medical Payment Systems Incorporated offices. Medical Payments Systems will direct the insurance claim to my insurance company electronically where it will be reviewed by any insurance company staff assigned to review claims. I understand that my insurance company will obtain information listed on the insurance claim about my diagnosis and the dates of my mental health treatment sessions. By my signature below, and as recorded on the HIPAA consent form, I am giving Psych and Psych Services permission to release all data necessary to my insurance company to determine eligibility and to process my insurance claim electronically. I realize that my insurance company may choose to make this information available to other entities, including other insurance companies. Furthermore, I authorize that payment of mental health/chemical dependency benefits be made to Psych and Psych Services. Any questions that I have about confidentiality can be answered in the Notice of Privacy Practices found in the waiting room (abridged version is given to all clients). I have also signed the HIPAA acknowledgement form and understand my client rights and the rules regarding release of Protected Health Information. I have been informed that I can ask the Privacy Officer any questions regarding confidentiality of records, the complaint procedure, or other matters pertaining to my review of my record.

Although I have requested the office to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

***Certain special services (e.g. school psychological evaluations, report writing, some types of testing, court-ordered treatment/evaluation) are often not covered by insurance. It is the clients responsibility to determine what services are and are not covered by their health insurance. If you are being seen for any services other than psychotherapy it is strongly recommended you call your insurance carrier to verify coverage.**

***If you become involved in any legal matter that requires your therapist to testify in Court, or to prepare reports for your attorney or the Court, you will be charged $100.00 per hour for these special services. These services will not be billed to insurance as they are not mental health therapy/evaluation services. YOU WILL NOT NECESSARILY BE REMINDED OF THESE SPECIAL CHARGES.**

I understand that charges will be added to my account for professional services rendered by my therapist (i.e., phone contacts over 5 minutes, preparation of special forms, reports, court time, etc.). The fee for these services is $100.00/hour and is not covered by insurance. *The client will be reminded prior to the delivery of these services of the additional charges.* For Court-ordered Custody Evaluations the fee is $120.00 per hour for all services.

I am aware that I will be charged $60.00 for each appointment that I miss or cancel less than 24 hours in advance. I agree to pay this amount and I understand that this charge cannot be billed to my health insurance carrier. If I request a copy of my records I will be charged the rates listed in the Office Policies document I received.

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I have read and understand the financial agreement as detailed above. By my signature below I agree to abide by the terms of the financial agreement, fully understand the release of information to my insurance carrier, and agree to make all efforts to pay for services rendered in a timely fashion. I am signing this agreement prior to receiving any professional services and understand that should I choose not to proceed with my initial session due to my finding the terms of this agreement unacceptable I will not be charged for the canceled session.

Signature:_____Print Name_____Date Signed_____

Signature:_____Print Name_____ Date Signed_____

FINANCIAL AGREEMENT

PSYCH & PSYCH SERVICES POLICY ON CO-PAYMENTS, SELF-PAYMENTS, AND PAYMENT FOR SERVICES

(Please inform the secretary, or your therapist, if you do not understand or agree with this policy immediately!)

This brief addendum to our Office Financial Policy is to remind you that as a new client to our office it is very important each time you see your therapist for professional services that you pay your insurance co-payment amount (the amount your insurance policy says you must pay each time), or your self-pay amount (the amount clients without insurance pay), in the form of cash/check/credit card. If the client is a minor, or adult under guardianship, it is important that the client's parent or guardian make sure they come to each session with the proper payment for services. If the client comes alone, the parent or guardian must make arrangements for payment to be made at the time of the session. Failure to bring your proper payment to each session may result in you not being seen by your therapist that day, and your session may be re-scheduled. This decision is at the discretion of your assigned therapist.

Also, remember, regardless of your insurance coverage, you are ultimately responsible for the balance of your account for the professional services rendered. For this reason, it is VERY important that you track how much your insurance is paying for services. It is also necessary for you to know what your insurance coverage is. We check your benefits as a courtesy to you, but you are ultimately responsible for checking on and knowing what your coverage is. If your insurance reaches the yearly maximum, or does not cover certain services, you are responsible for tracking that and paying the balance. You can track this by paying close attention to the Explanation Of Benefits (EOB) form that your insurance company will send you

A bill will be sent every month to clients who owe the Practice money for their portion of the charges. A **1.5% monthly finance charge** will be added to your balance to cover the cost of billing and sending you a statement. This finance charge will only be added to your balance if you do not pay your portion of the bill, causing you to get a statement. To avoid this finance charge, we ask that you make sure at the time of service that you pay any deductible, co-pay, or outstanding balance in order to avoid the extra work and cost of sending out bills. Remember, interest will be charged on all outstanding balances. You will then get a statement in the mail. If your insurance company denies payment for any services, that amount will be transferred to your balance. We will be glad to continue to deal with the insurance company on your behalf, but you will be responsible for any unpaid charges.

If you have not heard from your insurance company within **40** days of your initial visit to our office, please assist us by calling your insurance company. After speaking with your insurance carrier, give us a call back and tell us what they said is causing the delay. Even if they do not actually deny the charge, you will still be expected to pay for anything not paid by your insurance company in a timely manner. We submit insurance claims as a courtesy to you, but it is ultimately your responsibility to know your benefit limits and to obtain payment from your insurance carrier.

We need to work together to ensure your insurance carrier pays their fair portion of your bill for services.

Remember, you can use a **credit card** to pay for any services rendered at our office. We sincerely appreciate your cooperation in helping us keep your account balance paid in full as you receive professional services at Psych and Psych Services.

Clients who pay for services using a check returned due to insufficient funds will have **$40.00** added to their account to cover bank costs and staff time in re-processing your payment.

Any clients who are covered by Medicaid must bring their proof of Medicaid coverage with them each month. Failure to do this could result in an interruption of services.

Should your address, name, other identifying information, or insurance coverage change please be aware that it is the responsibility of the client to inform Psych & Psych Services. Insurance denials or delays in insurance payment due to your failure to provide us with updated information could result in your payment for service unnecessarily going up. Please notify us promptly of any changes in any of your personal information.

By way of my signature, I am agreeing to the Psych and Psych Services financial policy as described above. I understand that this policy is to inform me of the importance of paying for services rendered as they are being delivered. I have been informed of the extra billing charges (1 ½ % monthly finance charge on any outstanding balance for each month or partial month) I will incur for not keeping my balance zero (and generating a monthly billing statement) and I agree to pay those charges. Payment is due at the time services are rendered. Furthermore, I understand it is my responsibility to understand how much of the service my insurance company will cover and how much I am responsible for paying. Interest will be charged on all outstanding amounts that result in you receiving a monthly statement at the rate of One and One-half Percent (1 ½ %) per month on any outstanding balance for each month or partial month. All such sums are and remain the responsibility of the client, regardless of any insurance. By accepting services from Psych and Psych Services, I agree to these payment terms and interest charges.

If I do not pay my outstanding balance for three (3) consecutive billing cycles my account will be turned over to collections.

I am also fully aware of the $60.00 charge if I do not cancel an appointment providing the office with at least 24 hours notice. I am aware this is an office policy and is not negotiable, regardless of the reason for the late cancellation or missed appointment. I am aware that there will be no exceptions made.

I understand that copays must be paid at the time of service. Failure to do so will result in a $5.00 charge in addition to the copay.