Choices Psychotherapy

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7975 Stone Creek Drive, Ste. 130 • Chanhassen, MN 55317
7901 Xerxes Ave S., Ste. 225 • Bloomington, MN 55431

Billing/Payment Policy

Client Name:	Date of Birth:	Today's Date:

Choices Psychotherapy is dedicated to providing you with high quality mental health care. We are in-network providers with most insurance companies and will submit invoices to them for payment on your behalf.

1. Clients wishing to use insurance benefits need to provide Choices Psychotherapy with their current insurance information when scheduling the first appointment. This includes secondary insurance, if applicable. We will verify benefits and obtain necessary authorization.
2. **Verification of benefits is not a guarantee of payment** and it is the clients' responsibility to call the customer service number on the back of their insurance card to have a full understanding of what services are covered in addition to knowledge of your co-pay, deductible, and co-insurance prior to your initial appointment. It is also the clients' responsibility to notify Choices Psychotherapy of any insurance changes throughout the duration of treatment. Insurance claim denials will be the responsibility of the client to pay.
3. Clients are required to pay for all sessions at the time of service unless client is utilizing insurance benefits. Those not using insurance are required to have a valid credit card on file. Therapy fees are $200.00 per session. Psychiatry fees are $475.00 for an initial evaluation, $400.00 for an hour follow-up and $200.00 for a half hour follow up appointment. We accept check, cash, or credit card.
4. A NSF fee of $40.00 will be collected on all returned checks.
5. CO-PAYMENTS are due at the time of service. We cannot waive copays, co-insurance or deductibles. If financial difficulties or hardship arise, clients are encouraged to call Choices Psychotherapy's billing department at 952-544-6806, option 3 to make payment arrangements.
6. Services will be suspended for accounts 90 days past due. A client may discontinue services at any time, and by signing this document the client agrees to pay all outstanding balances associated with their account by the statement due date. Failure to do so will result in the account being sent to collections. Court fees may be assessed if applicable.
7. Clients will be notified via email, text, or mail every 21 days for any accumulated balance. Payment is expected by the statement due date.

Cancellation/No Show Policies

- **CANCELLATION OF SCHEDULED APPOINTMENTS MUST BE DONE 2 BUSINESS DAYS PRIOR TO APPOINTMENT.**

  - **THERAPY:** If the 2-business day cancellation requirement is not met, a **$75 "Late-Cancel" fee will be assessed.** If a client is able to reschedule the missed appointment within the same week, fees will not be assessed. **"No-Shows" will result in a $100.00 fee and all future appointments may be cancelled.**

- If **two therapy appointments are missed**, either by **"Late Cancellation" or "No-Show", all future appointments may be cancelled**. If recurring appointments are cancelled, it is the client's responsibility to make contact with their therapist, and to present a plan to reestablish services, which initially may be done on a "same-day" appointment basis, per the availability of the therapist and clinical necessity. Termination of services may also be considered by the therapist.

- **PSYCHIATRY:** If the 2-business day cancellation requirement is not met, a **$100.00 fee will be assessed. It may also result in no future appointments being scheduled. "No-Shows" will result in a $200.00 fee and all future appointments may be cancelled.**

- **All assessed late cancel or no-show fees will be collected AT CHECK-IN prior to next encounter with provider, OR with payment of invoiced monthly statement, WHICHEVER COMES FIRST.**

- Insurance companies do not pay for missed appointments. Failure to attend scheduled appointments may result in all future appointments being cancelled. Instances of this fee being waived require a provider's recommendation due to client extenuating circumstances and administrative approval.

Written Acknowledgement of Billing & Cancellation Policies

I have read this document and it has been explained to me. I understand and agree to the terms.

Check One Box For Payment For Service (check one)

- ☐ I authorize Choices Psychotherapy to release all billing and medical information regarding my diagnosis and therapy and/or medication treatment, and substance abuse if applicable to any third-party payer, when such information is requested for payment utilization review or coverage determination purposes.
- ☐ I am making payment for services directly; therefore, I am not authorizing a release of information for billing purposes.

Reminder Notifications For Services & Cancellation Policy (initial ALL indicating your understanding)

- _____ I understand that reminder notifications for ongoing sessions are a courtesy and will be made via email or text messaging. I understand that I am responsible to remember and attend my scheduled appointments.
- _____ I understand Choices' cancellation/change policies and agree to provide the required notification if I must cancel/change my appointment.

- **I have read this document and it has been explained to me. I understand and agree to the terms. My signature below means that I understand and agree with all the points above.**

Patient/Client Signature	Date	Print Name
Parent/Guardian Signature if client is a minor	Date	Print Name