Choices Psychotherapy

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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. We will verify benefits and obtain necessary authorizations.
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. It is also the clients' responsibility to notify Choices Psychotherapy of any insurance changes. Failure to do so, which could result in a claim denial will then be the responsibility of the client to pay.
3. It is your responsibility to know your co-pay, deductible, and co-insurance prior to your initial appointment. Clients are required to pay for all sessions at the time of service, unless coverage through an insurance plan for which we are providers has been verified. Therapy fees are $175.00 for an initial assessment and $175.00 for follow-up sessions. Psychiatry fees are $475.00 for an initial assessment and $350.00 per hour follow-up session and $175.00 per half hour follow-up session. We accept check, cash, or credit card. **A NSF fee of $40.00** will be collected on all returned checks.
4. CO-PAYMENTS, in the form of check, cash, or credit card must be made at the time of service. **Failure to pay your copay will result in a $5.00 fee.** We cannot waive co-pays, co-insurance or deductibles.
5. If your insurance requires a co-insurance and/or deductible to be paid by you, this amount is due when the claim is processed. **Choices Psychotherapy requires a credit card on file for all clients with a deductible and/or co-insurance. Your credit card, encrypted and stored securely, will be charged on the 2nd of the month for any unpaid balance in the previous billing cycle.** ***Clients are requested to and always have the opportunity to pay on-line, by mail or in person, prior to their card being charged.***
6. Statements will be mailed to clients on a monthly basis. **For accounts with a balance due, payment is due by the 1st of the following month.** A $10.00 late fee will be added to accounts 31 days past due and an additional .665% interest will be added per month thereafter. Service(s) may be temporarily interrupted for balances past 31 days until arrangements for payment is made.
7. If financial difficulties or hardship arise, the client must call Choices Psychotherapy's billing department at 612-212-8244 to make acceptable payment arrangements. These arrangements will be determined on a case-by-case basis. A 1.5% per month finance charge will be assessed on all client balances over 30 days.
8. **A client may leave therapy at any time, and by signing this document client agrees to pay all outstanding fees associated with their account immediately. Failure to do so will result in additional fees being assessed, including Court filing fees if applicable.**

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 "Late-Cancel" 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 being cancelled.**

    - **Consideration to be rescheduled for No-Shows will require a patient letter be written to the Psychiatrist, requesting reinstatement of services. A No-Show fee will also be collected.**

  - 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 providers 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.

- **My signature below means that I understand and agree with all of the points above.**

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

Effective: 4/1/2019