



KITSAP FAMILY WELLNESS

NURTURE. CONNECT. HEAL.

3587 NW Anderson Hill Road
Silverdale, WA 98383
360-434-7097 Direct
360-698-5967 Fax

FINANCIAL POLICY

We at Kitsap Family Wellness, LLC are committed to providing you the best possible experience we can, and we want you to feel as comfortable as possible. This includes your understanding of the services we provide you as well as our financial policy. We realize that the financial aspect of your experience is very important to you. We offer different financial options depending of the type of service offered and are happy to discuss them with you at any time. (Please see cost sheet for detailed costs.)

Many people are under the impression that if they have health insurance it is the insurance company which owes for the psychology services provided. This is not the case. **The health insurance contract is between the client and the insurance company. Therefore, the client is responsible for the bill regardless of the insurance coverage.** As a courtesy we will bill your primary insurance company if it is appropriate for us to do so; however, the responsibility for payment will remain with you. In order for us to bill your insurance you must provide us with complete information about your coverage including any necessary forms and group numbers. If you have additional coverage you will be responsible for billing your secondary insurance company. Please note that various procedures are not covered by insurance.

If you are covered by insurance and it can be billed for services, we will accept assignment of benefits which means you must sign the portion of your form that "assigns" payment to our office. Most insurance plans do not cover 100% of the cost of your services and require you meet a deductible before they begin to reimburse for services. In addition, insurance companies will not reimburse for certain diagnoses or forms of treatment. You will be responsible to cover the portion of services not paid by your insurance coverage (or your co-pay). There will be a finance charge charged to you in the amount of 18% annually or 1.5% per month on any unpaid balance over 60 days. Any amount that you have overpaid will be refunded to you.

These are things you can do/need to know:

1. Be familiar with the coverage and deductible on your insurance plan(s). You can get this information by reading your insurance booklet, calling your employer, or calling your insurance company.
2. Please be aware if your provider is covered under your insurance plan. Even if he is not a provider listed on your insurance plan most insurance companies will reimburse for treatment as an out of network provider. Be familiar with what this means in terms of reimbursement rates.
3. Bring your insurance card with you to your first visit.
4. At the time of service, payments may be made with cash, check, VISA, or MasterCard. Delinquent accounts will be referred for collection. Patient "No Show" for scheduled appointments will be assessed the full charge for services scheduled if not canceled within 48 hours of the time of service. Also, any check returned for non-payment will be assessed a \$25 "Returned Check Charge."
5. By signing this you agreed that fees for services can be raised at any time, by a reasonable amount, without notice to you.
6. We maintain your credit card on file, and you agree that it can be charged at the end of each billing cycle for the amount due on your bill.

I acknowledge that I am financially responsible for all charges attributed to me, whether or not they are covered by insurance. If it becomes necessary to effect collections on any amount owed on this or subsequent visits the undersigned agrees to fees assessed by the collection agency contracted to collect unpaid balances and all costs and expenses, including reasonable attorney fees. I hereby authorize a release of information necessary for such collection.

Signature: _____

Date: _____