Integrity Counseling

Billing Authorization and Payment Policy

Please read, ask us any questions you may have and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please come prepared to pay your co-payment at each visit.

3. **Non-covered services**. Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services, in full, at the time of visit.

4. **Proof of insurance**. All patients must complete a patient information form before seeing their counselor and provide us with an up to date copy of your insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes**. If your insurance changes, please notify us **BEFORE** your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45days, the balance will automatically be billed to you.

7. **Non-payment.** If your account is over 90 days past due or your balance exceeds $200 you will not be able to schedule another appointment until appropriate payment arrangements are made. Any account that continues to be unpaid beyond the 90 days may be subject to collections.

8. **Missed appointments**. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

9. **Statements.** Account statements will be sent monthly if a balance is due. Payments are due within 10 days of receipt. Payments may be made via check, credit/debit card or paid online. Statements are sent to the responsible party noted on the Intake Questionnaire.

☐ **I have read and understand this Billing Authorization and Payment Policy terms and agree to abide by these guidelines.**

Signature:_____ Date:_____

Print Name:_____

Credit Card Authorization / Decline

☐ I **do not** wish to authorize credit/debit card payment at this time, therefore I will be making payments at the time of service. Please mail my statement to me monthly, or anytime there is a balance due. If you select this option, **please date and sign here.**

Signature:_____ **Date**:_____

Print Name:_____

To provide credit card information for use by this office, please check the authorization option that applies, sign and date below.

By authorizing payment via credit/debit/HSA card, I acknowledge that charges will be applied to my card, to the maximum indicated below, at the time they become due.

☐ I authorize Integrity Counseling, LLC to charge my credit card an amount not to exceed $ _____ per charge. Please notify me prior to applying these charges. **Please complete the credit card information and email address below, date and sign**.

-OR -

☐ I authorize Integrity Counseling, LLC to charge my credit card an amount not to exceed $ _____ per charge. No prior notification is necessary prior to applying these charges. **Please complete the credit card information and email address below, date and sign.**

Charge notifications and/or credit/debit card receipts will be emailed to the address provided below

Email: _____

Patient Name: _____

What kind of account: ☐HSA ☐Debit ☐Credit ☐Other_____

Credit Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Name on Card: _____**Expiration Date**: _____**CVV Code**: __ __ __

Billing Address for above cardholder: ☐ Same as Mailing Address

Street:_____

City:_____State:_____Zip Code:_____

☐ **This credit/debit authorization is in effect until I revoke it in writing.**

☐ **I have read and understand this credit/debit/HSA card authorization and agree to abide by its guidelines.**

Signature:_____ **Date**:_____

Print Name:_____