SANTA ROSA COUNSELING CENTER
Therapy & Psychiatric Services

Financial Policy

INTRODUCTION

The purpose of this document is to explain service rates, payment responsibility, and appointment policies. This legal document establishes financial guidelines for your participation in services with us. Please read it carefully and discuss any questions or concerns with office staff and/or the mental health professional before signing.

PAYMENTS

Payment including, but not limited to, insurance copayment and cost anticipated to apply towards deductible are due at time of service. Accepted forms of payment are cash, check, money order, credit card, and Health Savings Account (HSA) card.

FEES FOR SERVICE

Psychotherapy Evaluation	$150	Psychiatric Evaluation	$235
Psychotherapy (Individual, Couple, Family)	$125	Medication Management	$125
Group Psychotherapy	$35		

Professional services including report writing, telephone conversations, and consultation related to your care are billed at $125 per hour. When a provider is required to participate in legal proceedings, including, but not limited to, preparation, transportation, deposition, and court appearance, professional fees are billed at $250 per hour with a minimum of two hours. Professional fees are due by the patient or the parent/guardian of record, even if another party compels the provider to testify or participate in legal services. Professional fees are due prior and are non-refundable within 72 hours of the event.

HEALTH INSURANCE BENEFITS

Our providers are preferred network providers with most Health Insurance Plans and Employee Assistance Programs (EAP). A portion or all your service may be covered by your health plan. Copayment and deductible amounts are paid at the time of service as part of the health plan contract. Payment in full is required when your benefit coverage is not able to be verified. **You are responsible for any balance not covered or paid by your health plan for any reason.**

CANCELLATION AND MISSED APPOINTMENTS

Recognizing that appointment time may be limited, timely rescheduling allows our providers the opportunity to schedule another client without delay. **If you are unable to make your scheduled appointment, we must be notified at least 24-hours in advance or the prior business day, whichever time is greater.** If late notice of cancellation of an appointment occurs or if the appointment is missed, you will be charged for the professional time reserved just for you, as follows: the Full Service Fee for evaluation or $75.00 for follow-up appointment. This service cost will be charged to the authorized card-on-file for your convenience.

Initials	I understand my provider's professional time is reserved just for me. I understand my authorized card-on-file will be charged for the amount of the Full Service Fee for evaluation or $75.00 for follow-up appointment upon missing a scheduled appointment or providing late notice of cancellation

SLIDING FEES AND NON-DISCRIMINATION

It is the policy of Santa Rosa Counseling Center to provide mental health services regardless of the patient's ability to pay. For those who are uninsured and qualified, we offer sliding fees. Santa Rosa Counseling Center does not discriminate in the provision of services to an individual because the individual is unable to pay or because payment for those services would be made under Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).

NON-PAYMENT OF ACCOUNT

Failure to maintain your account in good standing may result in dismissal from the practice. Santa Rosa Counseling Center reserves the right to use a third-party collection agency and/or small claims lawsuit to resolve delinquent balances. The cost for pursuing action against a delinquent balance will be added to your bill and/or claims lawsuit. Checks returned for insufficient funds and credit card chargebacks are subject to a $25.00 administrative fee.

CREDIT CARD ON FILE

Santa Rosa Counseling Center requires a credit card authorization on file so that your balances can be paid as they occur. For your convenience, immediate authorized charges include any balance that is incurred as specifically defined in the subsections of this document. Eligibility of services may be re-evaluated without a valid credit card on file.



Last Four Card Digits | CVV | Exp. Date

					/	☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX

We utilize TransArmor which stores security tokens instead of sensitive credit card data. This system is certified PCI compliant.

FINANCIAL POLICY ATTESTATION

I attest that I have read this document completely, fully understand it, and agree to all described herein. I authorize Santa Rosa Counseling Center to securely encrypt and retain my credit card information for the purposes of payment for any balances, including late cancellation and no-show fees, without additional authorization. I understand that I must provide an updated valid card when my current card expires or does not have an available balance. Revocation must be submitted in writing. I have had the opportunity to discuss any questions regarding this document.

Patient Name _____ Signature _____ Date _____

If you are signing this document as a parent, guardian, or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

Name _____ Relationship _____ Signature _____ Date _____