SANTA ROSA COUNSELING CENTER
Therapy & Psychiatric Services

Financial Policy

INTRODUCTION

The purpose of this document is to explain payment responsibility, service rates, 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

All payments including, but not limited to, insurance copayments and deductibles are due at time of service. Accepted forms of payment are cash, check, money order, and credit card.

HEALTH INSURANCE BENEFITS

Our providers are preferred network providers with most Health Insurance Plans and Employee Assistance Programs (EAP). A portion or all of your service may be covered by your benefits. Copayments and deductibles are paid at the time of service as part of the insurance provider 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 insurance company for any reason.

FEES FOR SERVICE

Service	Psychotherapy	Psychiatric/Medication Management
Initial Evaluation	$125	$150
Follow-up session, Individual	$100	$75
Follow-up session, Family and Couples	$125	
Group Session	$35	

Professional services including report writing, telephone conversations, and consultation related to your care are billed at $100 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 $150 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.

CANCELLATION AND MISSED APPOINTMENT POLICY

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. Recognizing that appointment time may be limited, timely rescheduling allows our providers the opportunity to schedule another client without delay. If late notice of cancellation occurs or if the appointment is missed/forgotten, you will be charged $75 for the professional time that was reserved just for you. If you have an authorized card-on-file, the balance will be charged to the card for your convenience.

Initials	I understand that my provider's professional time is reserved just for me and that I will be charged $75 for missing an appointment or providing late notice of cancellation. The balance will be charged to the authorized card-on-file.

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 bad-faith 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 settled 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.

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

CREDIT CARD ON FILE ATTESTATION

I authorize Santa Rosa Counseling Center to retain and charge my credit card on file for all valid assessed rates, fees, and late cancellation/missed appointment charges as specifically described in the subsections of this document. I understand that I must provide an updated valid card when my current card expires or does not have an available balance.

Last Four Card Digits				CVV	Exp. Date
					/

☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX

Name as it appears on card (please print) Signature of Cardholder/Authorized User Date

Revocation of this authorization must be submitted in writing.

OFFICE USE ONLY ☐ SWIPE ☐ MC/NR INIT _____

FINANCIAL POLICY ATTESTATION

I attest that I have read this document completely, fully understand it, and agree to all described herein. 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