



ATTENDANCE AND BILLING POLICIES

(Please initial beside each policy as an indication you have read, understood, and agreed to the content.)

_____ LENGTH AND ATTENDANCE OF SCHEDULED SERVICES:

Each session will be 50-60 minutes in length. Your session will end at the scheduled time, even if you arrived late to your appointment. With advance notice, you can reserve a 90 minute session, as needed. However, additional fees would apply, that may not be covered by your insurance.

_____ PAYMENT/CO-PAYMENT:

Payment/Co-Payment for each session is due in full at the time of your appointment. If you are using an in-network insurance company, your co-payment and/or deductible is determined by your insurance company. If you are using an out of network insurance you are responsible for the full-service fee. If a bill is submitted to your insurance company, you may get money back if you have out of network benefits; though it is your responsibility to find out this information and submit to your insurance company. Pathways to the Heart...LLC., will provide you a super bill for your convenience for submission. Some out of network insurance companies Pathways to the Heart...LLC can submit a bill for you though the above remains the same where you are responsible for the service fee if your insurance company is not covering the costs if you don't or have not met your out of network reequipments. For all payments, co-payments, and other fees, your credit card information is securely kept on file for your convenience so you do not have to remember payment/co-payment at the time of your session. Your card will usually be charged on the same day of your session and/or within 24 hours. If your credit card is not accepting the charge due we will ask you to provide another method of payment. Standard therapy sessions are either 30, 50-60, or 90 minutes in length. The standard **30-minute fee is \$75/session**, the standard **50/60-minute fee is \$150/session** and the standard **90-minute fee is \$180/session**. A reduced fee-for-service may be offered on a limited basis. If agreed on a reduced rate the rate agreed on is \$_____ (AB). Payments can be made via credit cards (HSA or FSA accounts may be used), cash or checks (made payable to Pathways to the Heart..., LLC) are also accepted. Non-payment at the time of session will result in the credit card on file being charged unless other arrangements have been agreed upon.

_____ CANCELTION NOTICE:

We value our time with you and your time is reserved solely for you. **So please call, text, or email Pathways to the Heart...,LLC, at a minimum of 24 hours before your scheduled time.** Exceptions of the policy include; prohibitive inclement weather, car accidents, deaths in the family, or extreme illness, that occurred within your 24 window of cancelation. **If you cancel with less than 24 hours notice of your scheduled appointment, your card on file will be charged \$75.00 unless we agree on another payment method.** Please note, if you use insurance, your insurance company will not be charged for this missed session, and it is your responsibility to pay this \$75 fee. Also note, this **does not** apply to clients who have **Husky** insurance, as there is no charge for cancelation. Any excessive cancelations (3 or more in a short time period), closing of the file will be discussed, and you will be given other referrals for another therapist, or you can resume therapy when you are better able to demonstrate consistent attendance, which is critical to therapy.

_____ "NO-SHOWS":

A no-show occurs when a client does not call ahead of time to cancel an appointment and does not attend a scheduled session. Cancellation outside of the designated cancellation window will be considered a no-show, and

the client will be charged **\$75.00 for the missed session** (unless you are a Husky client). A total of **three (3) no-shows** will result in **termination of services** and you will be provided with appropriate referral resources. Services may be reinstated at a later date; however, the intake process must be repeated. At any point, if therapy is ended and if you have an outstanding balance, you must pay your remaining balance before reengaging in services.

_____ INSURANCE REJECTION:

If, for some reason, your insurance claims are rejected due to cancellation of insurance policy or another concern, you will be responsible for the payment of services at the rate your insurance company pays for my services. We will make attempts to submit claims to your insurance company and make any and all necessary phone calls to rectify the billing situation. If, after these attempts, the claims continue to be denied, you will be billed directly for the services, and/or charged via your card on file. We will notify you when charging the card for any balance. You will be responsible for contacting your insurance company to submit for reimbursement. If there still remains a balance to your account after 30 day the credit card kept on file will be charged the balance in addition to a \$10 late fee.

_____ LATE PAYMENT FEE:

If your account carries a balance for an extended period of time, you will be charged a late fee of \$10/month for every month there is an existing balance on your account. In extreme cases where your balance is not paid after all attempts to contact you, charge credit card on file, your balance may be sent to collections.

_____ EXTENDED PHONE CONSULTATIONS:

Your therapist is available for phone consultations outside of session regarding brief administrative (scheduling, finances, etc.), and brief therapeutic planning. Generally, these conversations last 5-10 minutes and tend to be infrequent. If a phone conversation lasts longer than 15 minutes in duration or the nature of the phone call is therapeutic rather than administrative, your therapist may charge a prorated amount of your session fee, of \$5 per every 5 minutes thereafter.

_____ INACTIVE STATUS:

Your client file will become inactive after sixty (60) days of non-attendance to a session. You are welcome to continue counseling with Pathways to the Heart...LLC, again at any time, though all balances must be paid in full.

_____ ADDITIONAL FEES FOR EXTENDED ADMINISTRATIVE/CONSULTATION TIME AND/ORCOURT-RELATED MATTERS:

Sometimes, correspondence with other agencies (insurance, courts, doctor, other mental health professionals, etc.) is required. Most phone contact or brief letters to medical or mental health professionals regarding your case will be a complimentary part of our services; however, any communication, verbal or written that involves the court system, attorneys or litigation will be billed the full private practice fee of \$150/hr (prorated by the .25 hour), not at the agreed session fee. If a therapist of Pathways to the Heart..., LLC, is required to appear for any court related meetings, including depositions or expert witness appearances, you will be billed in full for the preparation time and the amount of time that the therapist is required to block out his or her schedule, regardless of whether the appearance takes place once the cancellation is less than 72 hours (3 days) from the required appearance. For example, if your counselor is subpoenaed as a witness, and s/he is required to block 4 hours of clinical time for the appearance, you will be billed for 4 hours, and 72 hours notice of settlement or cancellation of the appearance is required.

_____ EXTENDED (Cumulative >2 Hours) COMMUNICATION WITH MEDICAL/SOCIALWORK/MENTAL HEALTH PROFESSIONALS:

Extended letters or contact (cumulative 2+ hours) with other mental health, medical or social work professionals may eventually result in these same prorated charges. In all correspondence, you will need to sign an Authorization for Release of Information.

_____ PHONE CONTACT AND EMERGENCY POLICY:

You may contact the office by dialing 203-941-1739. Pathways to the Heart..., LLC, is not 24-hour emergency care. A client cannot assume that a therapist will be available at all times. In case of an emergency and the inability to reach Ashlie Befus (owner & therapist), immediate contact should be made to 211 for crisis services, call 911 and/or go to an emergency room, if you feel your life or the life of someone else may be at risk.

I have read the above Attendance and Billing Policies carefully. I understand them and agree to comply with them:

Client's Name (print) _____
Signature _____ **Date** _____

Second Client's Name (print) - as needed _____
Signature _____ **Date** _____

Parent or Guardian's Name (print) as needed _____
Signature _____ **Date** _____



CREDIT CARD INFORMATION FOR FILE

By signing below I hereby authorize Pathways to the Heart...LLC, to charge the card listed below for payment of fees including: session fees, copays and cancellation charges, or any other authorized charges as listed above, which are incurred for therapeutic serviced of the authorized user(s) and/or family member (in case of consenting for the minor client).

Name on credit card: _____

Billing Address: _____

City: _____ State: _____ Zip code: _____

Type of credit card: VISA MasterCard American Express Discover

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

***All hardcopy credit card information is kept as HIPAA protected information behind multiple locks.*

1. **I understand that my card will be charged \$75 automatically in the event of a missed or no show appointments were the minimum 24-hr notification was not given.** Exceptions to this per the cancellation policy, include prohibitive inclement weather, car accident, death of a family member, and/ or an onset of sudden/serious illness occurring within the 24-hour time frame.
2. I understand that if I decide to at any time to terminate the services provided by Pathways to the Heart...LLC, and my account is paid in full this authorization to charge my credit in the future will also be terminated. If I choose to come back in the future I would need to reauthorize a credit card to have on file.
3. I agree that all information provided is accurate and complete. I also acknowledge that if any charges are declined or charge backs are claimed against any outstanding invoiced amount, I will be expected to pay the invoiced amount plus any added costs and fees in cash. If this is not paid, the statement may be sent to a collection agency.

Signature _____ **Date** _____