Darbouze Behavioral Health Services of DARBOUZE, LLC
Phone: 856-200-3522/ Fax: 856-242-2955

PAYMENT POLICY

Our therapists are committed to providing the highest quality of therapy and to ensure our ability to do so, we have established the following. This information is provided to prevent misunderstandings concerning payment and professional services.

Insurance Card: It is your responsibility to bring your current insurance card to every visit to ensure we have the correct filing information. Eligibility for coverage by health insurance plans is not a guarantee of payment. If it is determined that you are not eligible for coverage, you will be required to pay in full for all services when rendered.

Secondary Insurance: We do file claims with secondary insurance plans, but you must pay co-pay/deductible.

Payment Due at Time of Service: You are required to pay any primary insurance co-payments, deductibles, and/or coinsurance at every appointment. We accept cash, checks, Visa, MasterCard and Discover.

Collection for Non-Payment: You will be responsible for any and all costs involved in collection for non-payment. This includes collection agency fees, legal and/or court costs and billing fees. When using credit or debit cards, you will be charged a $3.00 fee.

Self-pay Patients: You are required to pay in full for services rendered at the time of service. If you are unable to pay in full, you must make payment arrangements with the receptionist prior to your appointment.

Checks/Pre-or Post-Dated Checks: Checks returned for insufficient funds, you will incur a $25.00 charge, and we will automatically redeposit the check. If the check is returned a second time, another $25.00 service charge, plus the face of the check will be charged back to the patient's account and will be due immediately in an alternate form of payment. If you need to pre or postdate a check, please make that arrangement with our cashier prior to the appointment.

Care of a Minor: If the patient is a minor (17 years and younger), a parent/guardian must sign below. An unaccompanied minor is responsible for any payment due at the time of service, as well as presenting all required referral and insurance information.

By signing below, you acknowledge our Payment Policy. Our therapists and staff firmly believe that a positive relationship is based upon understanding and good communication. Please sign that you have read, understand, and accept here at Darbouze, LLC.

Signature_____ _____
Signature of Patient or Patient's Legally Authorized Representative — Date

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other

_____

Thank you for choosing Darbouze, LLC

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The Presidential Center, 101 Route 130 South, Madison Building, Suite 300
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