Fresh Perspectives Counseling and Consultation Services, LLC

FINANCIAL POLICY AND MISSED APPOINTMENT POLICY

Welcome to Fresh Perspectives Counseling Services. Please read over our financial and missed appointment policy. If you have questions, feel free to ask.

FINANCIAL POLICY

Fees. Sessions, whether counseling or consultation, are generally 55 minutes long (an explanation of the differences in session structure are outlined in the INFORMED CONSENT form). The fee for a 55 minute counseling session, either face-to-face or by phone, is $156. The fee for a 55 minute consultation session, either face-to-face or by phone, is $85. Payment is collected at the first of the session. We would ask you to place a credit card on file as explained below.

Charges. Occasionally there are additional charges or other related fees. Please ask any questions you may have about these additional services which can include, but are not limited to, court presence, agency advocation, etc… We will discuss the potential for any additional charges before they are assessed.

Insurance Patients. If you have health insurance, Fresh Perspectives Counseling and Consultation Services, LLC is happy to call your insurance company and verify your insurance benefits. They will also file your insurance for you. If your insurance covers a portion of your services, we will be happy to wait for 60 days for your insurance to pay their portion. You will, however, be responsible for your deductible and co-pay or co-insurance. That portion of your care will be due at the time of your appointment. You will be responsible for all charges not covered by your insurance company.

Self-Pay Patients. Patients without insurance or with high deductibles are responsible for the cost of their care. Payment is expected at the time the service is rendered.

Methods of Payment. Fresh Perspectives Counseling and Consultation Services, LLC accepts as payment for services cash, checks, and major credit cards.

Payment in Advance. If you or your therapist anticipate more than ten visits, you may pay for them in total and in advance to receive a discount of 10%.

MISSED APPOINTMENT POLICY

Twenty-four hour notice is required for the cancellation of an appointment. Appointment times can be difficult to come by and we ask you respect the time we set aside for your session. *Appointments canceled with less than 24 hours notice will be charged a fee of $50, this amount will be charged to the credit card placed on file.* Appointments missed because of inclement weather or other justifiable issue will not be charged.

CREDIT CARD GUARANTEE

[ ] UNINSURED PATIENTS

Patients who are uninsured or whose insurance does not cover the cost of mental health counseling because of high deductibles or other limitations are personally responsible for payment. Any balance not paid by the end of the week will be automatically charged to your designated card below. This procedure will enable you to spread out your payments if you wish and make them smaller while keeping your account current.

[ ] INSURANCE ASSIGNMENT

Our Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your health insurance carrier on your behalf and wait up to 90 days for payment. Please remember, however, that you are ultimately responsible for payment. On Day 90, if the bill has not been paid by your insurance company, we will charge your designated credit card below for the amount of the claim. Any payments made on these claims thereafter will be immediately refunded to you.

I agree to the above terms and authorize you to charge any payment not paid by the end of each week to the credit card below.

____ ____________________

SIGNATURE DATE

CREDIT CARD: _____AMEX _____VISA _____MasterCard _____DISCOVER

CARDHOLDER'S NAME ____

BILLING ADDRESS ____

CARD # ____ EXP. DATE __________ THREE DIGIT CID # ________

***** This information will not be used in any way other than as agreed upon in this document*****

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the therapist or therapist's office. I authorize the therapist to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of therapy and counseling care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

The patient/client understands and agrees to allow this healthcare office to use his/her Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the waiting area before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

I have read and agree to the above conditions.

Patient's Signature: ____ Date:______________

Guardian's Signature Authorizing Care: ____

Date:_______________