FINANCIAL POLICY AND CONSENT FOR BILLING

You are responsible for full payment of my fees at the time that services are rendered. I accept cash, personal check or credit cards (Visa, Mastercard, American Express) as payment. You are responsible for any returned checks or credit card charges and any fees incurred from returned payments.

Should you elect to use your medical insurance to pay for your treatment, or if you choose to directly seek reimbursement from your insurance company on your own, please note the following:

- You are responsible for contacting your insurance company to verify your mental health coverage, namely which services are covered, your insurance deductible (if any), whether a referral or pre-authorization are needed, and whether there is a limit to the number of sessions your policy will cover.
- You are aware that your insurance company may limit the number of sessions they are willing to cover. When you are approaching the limit of covered services, we can discuss your progress and you can decide whether you want to continue treatment without using your insurance.
- You are responsible for obtaining any necessary referrals for treatment before treatment can be provided, otherwise it may not be covered by insurance.
- Your co-pay is due at the time that services are rendered.
- As also noted in the "Informed Consent for Therapy Services," you are aware that I must provide you with a clinical diagnosis, and you are agreeing to authorize me to provide that diagnosis to your insurance company. This diagnosis will remain part of your health record and may be considered a pre-existing condition in the future. At times, I am required to provide the insurance company with more detailed clinical information, such as treatment plans or summaries, or in rare cases, a copy of your entire clinical record. Information released to the insurance company is stored electronically by them and I have no control over its security or who can access your information once it is released to them.
- I submit claims electronically to your insurance company through a third party, and again, I have no control over how they secure or maintain your protected health information.
- You will be responsible for any balance not paid or denied by your insurance company.
- You must inform me of any changes in your insurance coverage as soon as possible to avoid claims being denied.
- You are financially responsible for any claims that are denied or not covered by your insurance for failure to obtain a referral or notify me about any changes to your insurance company, member identification or group numbers, or your policy coverage.

I have read and agree to the terms of the above information. I understand payment is expected at the time of services rendered and that I am responsible for any balance not covered by insurance.

I, _____, the insured (or authorized representative), authorize my insurance benefits to be assigned to the provider, Nicole Maus-Chaudhury and Finding Hope, LLC, and I authorize my insurance company to pay benefits directly to the provider.

I authorize the release of medical information and billing data necessary to process claims to my insurance company.

_____ _____

Signature of Patient or Personal/Authorized Representative Date

_____ _____

Printed Name of Patient or Personal/Authorized Representative Relationship of Representative to Patient