Behavioral Health and Wellness Associates

of Northern Virginia

4460 Brookfield Corporate Drive Suite H

Chantilly, VA 20151

(571) 261-8239 / Fax: (571) 933-6506

FINANCIAL POLICY

The *Person Responsible for Payment of Account* is required to sign this form, which explains the fees and collection policies of this office. At the beginning of treatment, you can make a choice to pay for services out-of-pocket or to file through insurance. If you choose to file claims through insurance, we will submit insurance claims, on your behalf, for those insurances in which we participate and for those services which have been determined to be covered under your insurance policy. We will not submit claims for services that are not covered by your insurance, and those fees will be due at time of the service. If we do not participate with your insurance carrier,we will provide you with appropriate documentation so that you may file claims under an Out of Network benefits. However, please be aware that if you file claims independently we cannot guarantee that your insurance company will agree to reimburse you.

Insurance deductibles and co-payments are due at the time of the service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g. if there previous visits to another mental health clinic since January of the current year prior to our first session), this amount will be collected by this office until the deductible payment is verified to this office or by third-party payor.

Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company. As a service to you, this office will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and is not responsible for the collection of such payments. In some cases insurance companies or other third-party payers may consider certain services not reasonable or necessary or may determine that services are not covered. Clients are responsible for payments regardless of any insurance company’s arbitrary determination of usual and customary rates.

The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 120 days are subject to collections. A 5% per month interest rate is charged for accounts over 60 days. All insurance benefits will be assigned to this office (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

**CLIENTS ARE RESPONSBILE FOR PAYMENTS AT THE TIME OF SERVICES**. The adult accompanying a minor is responsible for payments for the child at the time of the service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved charge card or unless payment is provided at the time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate noted in the clinician’s office policies. Payment methods include check, cash, or the following charge cards: MasterCard, Visa, Discover, and American Express. Clients using charge cards may use their card at each session or sign a document allowing this office to automatically submit charges to the charge card each session.

Please initial the appropriate selections:

\_\_\_\_\_\_ I (we) have read, understand, and agree with the provisions of this Financial Policy.

**Initial**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_ I choose to pay fee for services and do not wish to have claims submitted to my insurance. I

**Initial** understand that the fee per session is \_\_\_\_\_\_\_\_\_\_\_.

OR

\_\_\_\_\_\_ I understand that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ does not accept my insurance. The fee for

**Initial** the initial session is \_\_\_\_\_\_\_\_\_ and that the fee for each follow-up session is \_\_\_\_\_\_\_\_\_\_. I provide \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and Behavioral Health and Wellness Associates of Northern Virginia with permission to release information to my insurance company as deemed necessary for Out-of-Network benefits. I understand that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and Behavioral Health and Wellness Associates of Northern Virginia do not guarantee that my insurance company will reimburse me/pay for out-of-network services if I submit claims independently.

OR

**\_\_\_\_\_\_** I provide permission to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and Behavioral Health and Wellness Associates of Northern Virginia to submit insurance claims on my

**Initial** behalf and to provide the necessary information to file claims appropriately for in-network benefits.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Person Responsible for Account

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Co-responsible Party for Account

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Witness: Clinician