

MINDING YOU

DUI Services  Mental Health  Addiction Recovery  Evaluations

Stephanie Higdon LCSW, CAADC

FINANCIAL POLICY

Client Name / DOB: _____ Client Record #: _____

Minding You Staff verifies eligibility and benefits with Net Claims Medical Management, LLC / Lynette Clark. In the event that Net Claims is unable to pre-approve / verify your coverage, you will be asked to pay for services rendered until we can confirm your status. We will do all we can to assist you with your insurance claims however, insurance is a contract between you and your insurance carrier and the allowances and limitations of your coverage are your responsibility. Final responsibility for payment of your account rests with you.

____ I authorize Minding You to release to Net Claims Medical Management, LLC / Lynette Clark, billing information and treatment codes needed to determine and coordinate benefits payable for service.

____ I authorize Minding You to release to my insurance carrier, Medicare, or Medicaid CMO or their appointed agents any medical, demographic or treatment information needed to determine benefits payable for service.

____ I hereby authorize payment by my private insurance carrier, Medicare, Medicaid CMO, or other designated payor of any medical benefits, to Minding You, for services provided. This assignment will remain in effect until revoked by me in writing.

____ I understand and hereby authorize the release of my PHI to the stated parties, only as necessary, for billing, payment verification and service integrity / risk management auditing purposes by my insurance company or appointed affiliate.

____ I agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment, I agree to pay all collection/legal fees that may be added to my account.

Returned checks: A \$35.00 NSF fee will be charged for checks returned unpaid by your bank. Returned checks will not be re-submitted for deposit.

I understand the above policies and hereby authorize the release of my information to the stated parties above, as necessary, for the purposes of billing and insurance claim management, risk reduction and / or monitoring of service provision audits.

Client / Client Parent or Guardian Signature

Date

Therapist, Minding You
Stephanie Higdon, LCSW, CAADC

Date