Center for Integrated Well-Being

REGARDING INSURANCE-BASED ARRANGEMENTS AND FEE POLICY

This private practice is committed to providing you with the best possible mental health care. If you have insurance coverage with mental health benefits, I am eager to help you in seeking reimbursement for mental health services I have provided you.

If you use your insurance to cover mental health costs here, I will bill your insurance company directly and your responsibility is to pay the co-payment at the time of service. My preferred policy is that co-payments and / or estimated co-insurance for services are paid at the time of service unless other payment arrangements have been made with me.

Returned checks and non-payment plan balances older than 30 days will be subject to additional collection fees and finance charges of 1.5% per month. Full session charges per insurance reimbursement rates, (plus co-payments fees) will also be made for missed appointments and for appointments cancelled outside of 24 hours advance notice. An account that is delinquent for paying after 90 days may be sent to collections.

As your psychotherapist, I must emphasize that my relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that I extend to my clients, all charges are your responsibility from the date that services are rendered. I realize that inadequate insurance and/or temporary financial problems may affect timely payment of your account. If such problems do arise, I encourage you to contact me promptly for assistance in the management of your account.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read the above information and provided financial information that is true and correct to the best of my knowledge. I will notify you of any changes in any of the financial information relevant to my account and agree to pay the charges as described above for cancelled / missed appointments outside of 24 hours.

Signature: _____ Date: _____

(Parent or Guardian for Minor)