Holistic Counseling Services

I authorize Holistic Counseling Services to furnish information to their agents/insurance carriers concerning my treatment and hereby assign to Holistic Counseling Services all payments for medical services rendered to me or my dependants. I also understand that I am responsible for any amount not covered by my insurance.

Date_____ Signature_____

Holistic Counseling Services Financial Policy

Welcome to our practice! We are committed to helping you work within the framework of your insurance policy. All payments are due at time of service. We realize that temporary financial problems may effect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account, as it is our intent to never have the care of our patients compromised for financial reasons.

There are several important points to be made aware of:

1. Deductibles are the patient's responsibility. The deductible is determined by the contract you have with your insurance carrier. We do not know how much each person's deductible is and how much has been met at the time of your visit.
2. Co-insurance and co-pays are the patient responsibility. They are to be paid at the time of visit or a surcharge of $10.00 for billing will be added.
3. We submit claims to your insurance, but you are responsible for responding to any questions from the insurance carrier for further information. Not doing so will result in a claim denial and you will be responsible for payment.
4. If the insurance payment is sent to you erroneously, you are responsible for forwarding payment to our office promptly.
5. In the situation where the patient's parents are divorced or separated, our policy is that the parent bringing the child for the office visit is the responsible party. We cannot bill the other parent. However, either parent can make the payment prior to the scheduled appointment.
6. Returned checks are subject to an additional fee of $35.00 to cover banking fees.
7. In the event that your account is sent to collections, you agree to pay for all related costs and expenses, including attorney's fees.
8. Unless you cancel/reschedule your appointment within 24 hours of your scheduled appointment, a fee of $25.00 will be charged to your account . **If you fail to cancel a scheduled appointment, we are unable to use this time for another client. You will be billed for the entire cost of your missed appointment.** Please help us serve you better by keeping your scheduled appointment.
9. Someone with legal authority/guardianship must accompany all patients under the age of 18.

10. There is at least a $10.00 clerical fee for all state forms needed to be completed.
11. If you have any questions about the above information, please don't hesitate to ask. We are here to help you. Thank you for reviewing our financial office policy.
12. Sliding scale fees are based solely on income and household size. Client must provide proof of income for each household member. Such documentation may include the last 2 paystubs if paid biweekly and last 4 paystubs if paid weekly. Client may also provide a letter that includes from his/her employer if a job was recently obtained and he/she has not been paid yet. If self employed, client must provide copies of last income tax return. Sliding scale fees will be reviewed every 6 months. Additionally, the client also authorizes Holistic Counseling Services to release any billing information to third party agencies for processing.

I have read the above financial policy, as well as understanding and agreeing to the terms and conditions of such.

Patient's Name _____

Patient's Signature_____ Date _____

Revised July 24, 2012