Client Name: _____

Financial Policy

Thank you for choosing us as your mental health care provider. We are committed to your therapy being successful.

- Please understand that **you** are responsible for any co-pays, deductibles, and/or coinsurance applied to your balance by your insurance carrier.

- Payment is required at the time of service. **The amount to which you are responsible cannot always be determined prior to your receiving services.** We recommend you contact your insurance provider with questions about coverage and exclusions of your plan. You will receive a statement for the amount owed should there be a discrepancy, which is due immediately thereafter.

- We reserve the right to assess late charges and/or turn accounts over to collections with past due balances over 30 days in age.
    - If I fail to make payment within sixty (60) days after the date of service, I agree to pay a rebilling charge of one and one-half percent (1.5%) per month, which is an annual percentage rate of eighteen percent (18%) which will be charged on the unpaid balance of my account beginning sixty (60) days after the date of service. The minimum rebilling charge is $7.00

- There will be a $35 service charge on all returned payments.

Please let us know if you have any questions or concerns.

I HAVE READ THE FINANICAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

_____ Date: _____

Signature of the Client or Responsible Party

_____

Printed Name