

## Agreement of Financial Responsibility

Welcome to our practice. Thank you for choosing us as your mental health care provider. We deeply value the trust you've placed in us and are dedicated to offering compassionate, high-quality care and support to all our clients. To ensure transparency and mutual understanding, we kindly ask you to review and acknowledge the following financial policy prior to receiving any treatment. **Your initials in each section and signature at the end indicates that you have read, understood, and agree to comply with this policy and pay any indicated fees.**

**Initial  
Below**

\_\_\_\_\_ **1. Payment for Services:**

- Payment is due at the time services are provided.
- We accept cash, checks, credit cards, and approved insurance plans with which we are contracted, if applicable.

\_\_\_\_\_ **2. Insurance Coverage:**

- Familiarize yourself with your insurance benefits, including in-network status, covered benefits, policy exclusions, deductibles, and pre-authorization requirements to avoid unexpected charges.
- Provide current and accurate insurance details, including any updates or changes, to prevent unexpected charges.
- While we verify your insurance coverage before appointments, insurance companies may update policies, and coverage information may not be current. Your financial responsibility will depend on actual insurance payments.

\_\_\_\_\_ **3. Claims and Billing:**

- For contracted insurance plans, we will submit claims on your behalf. You are responsible for copayments, deductibles, and any non-covered amounts. Claims are typically processed within 45-60 days.
- For non-contracted insurance providers, payment for all services is required at the time of your visit. We will provide a detailed statement to assist with direct reimbursement from your insurance.

\_\_\_\_\_ **4. Secondary Insurance:**

- We will submit claims to primary and secondary insurers. You are responsible for costs typically covered by secondary insurance until payment is received. If/when your secondary insurance pays, that amount will be refunded to you.

\_\_\_\_\_ **5. Documentation Requirements:**

- Please provide proof of payment, a valid photo ID, and your insurance card. Providing your insurance card does not guarantee coverage or payment for services.

\_\_\_\_\_ **6. Out-of-Network Benefits:**

- Out-of-network services may result in higher co-pays, co-insurance costs, or limited annual benefits. Your financial responsibility may be greater compared to in-network services.

\_\_\_\_\_ **7. No-Show and Late Cancellation Policy**

We understand that life can be unpredictable, and sometimes appointments need to be changed or canceled. To ensure fairness and efficiency in managing our schedule, we have implemented the following policy regarding no-shows and late cancellations:

- **Cancellations:** Please provide at least 24 hours' notice if you need to cancel or reschedule your appointment. This allows us to offer the time slot to other clients in need of services.
- **No-Shows and Late Cancellations:**
- **First Occurrence:** We understand that things happen, so the first no-show or late cancellation (less than 24-hour notice) will be given a grace period without any charges.
- **Second Occurrence and Beyond:** A \$50 no-show or late cancellation fee will be applied to your account. This fee is due at the time of the missed appointment and must be paid before any additional services are rendered.
- **After the Third Occurrence:** We reserve the right to terminate services following a third no-show or late cancellation.
- **Payment of Fees:** Any outstanding balances, including no-show or late cancellation fees, must be paid in full prior to scheduling or attending your next session.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of and agreement to my financial responsibility. I understand that I am responsible for any charges incurred due to professional services rendered to me, as well as any of the fees associated with the conditions mentioned, including any fees denied coverage or payment by my insurance company for services provided. I assume full financial responsibility and will pay all such charges in full.

\_\_\_\_\_  
Signature of Patient /Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient/Responsible Party (please print)

\_\_\_\_\_  
Relationship to Patient