BILLING AND COLLECTION POLICIES

Client Name: _____ DOB: _____

Professional Fees

• Initial Diagnostic Assessment	$275
• 30 Minute Therapy Session	$100
• 45 to 50 Minute Therapy Session	$150
• 55 to 60 Minute Therapy Session	$225
• Family Therapy Session	$200
• Interactive Complexity	$25

Cancellation Policy

Once an appointment is scheduled, you will be expected to give 24 hours advanced notice of cancellation. There will be a fee for the missed session according to the following schedule:

• First No Show/Late Cancellation	$50
• Additional No Shows/Late Cancellations	$150

Please note that insurance companies do not pay for cancelled or missed appointments. Repeated cancellations and missed appointments may result in the termination of the therapeutic relationship. A letter reflecting termination will be mailed to you if this occurs.

Support Services

Initial phone calls made for case planning will not be charged unless the total time of the calls exceeds one hour. At which point, a charge of $25 will be incurred for each call lasting longer than 15 minutes. Other professional services, such as your request for my attendance at meetings with other professionals and preparation of records or treatment summaries, will be charged $150 per hour in 15-minute increments. Insurance companies do not reimburse support services.

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, mental health services may be fully or partially covered. However, it is ultimately your responsibility to pay for any and all expenses as they are incurred. If you have questions about your policy, it is recommended that you contact your insurance company to inquire about your mental health benefits and any requirements for authorization. Hope Psychology Practice, LLC, in collaboration with MB Billing Services, LLC, will provide you with assistance in seeking reimbursement for in-network and out-of-network coverage for mental health services. In circumstances of unusual financial hardship, Hope Psychology Practice, LLC may be willing to negotiate a fee adjustment.

Please be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans, summaries, or copies of the professional record. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen in the event that they run out before you feel ready to end our sessions. You always have the right to pay for my services yourself instead of going through insurance.

Payment

Hope Psychology Practice, LLC accepts cash, check, Visa, MasterCard, American Express, and Discover. We require you to leave your credit/debit card information on file for us to charge any copays, co-insurance, deductible amounts, support service charges, late cancellation, missed appointment, and/or any other out-of-pocket fee amounts that may accrue. Please be aware that Square sends receipts via email or text message. These receipts will include the business name, indicating that you are paying for psychological services. If you prefer not to receive such receipts, please pay via cash or check at the time of the appointment. All credit card charges will incur a _3%_ convenience fee. If an electronic payment is frozen or denied, you are responsible for ensuring that full payment is made by other means.

Outstanding Accounts

Our billing service provides monthly invoices if your account has a balance. If a balance accrues and no payment is received within 90 days of the date of service, Hope Psychology Practice, LLC reserves the right to seek payment by any means, including using the credit/debit card information we have on file, taking payment from family members whose information you have provided, retaining a collection agency, and/or taking legal action in court. If a payment plan is required, account balances between $1 and $499 will be charged at least $100 per month and account balances greater than $500 per month will be charged at least $150 per month.

Please complete the following payment sections.

Primary Insurance

Policy Holder Name: _____ Relationship to Client: _____

Address: _____

DOB: _____ Employer: _____

Insurance Company: _____

Policy/ID#: _____ Group Plan #: _____

Secondary Insurance

Policy Holder Name: _____ Relationship to Client: _____

Address: _____

DOB: _____ Employer: _____

Insurance Company: _____

Policy/ID#: _____ Group Plan #: _____

Credit/Debit Card Information

I, _____, agree that my credit card information and signature may be kept on file and confidentially maintained to pay for services that are rendered by Hope Psychology Practice, LLC for _____ (client name).

Name on Card:	
Credit Card Number:	Expiration Date:
Billing Zip Code:	CVV Code:
Signature:	

Agreement and Release of Information for Services

Please initial and sign the following:

_____ I have read and understand the above described billing policies.

_____ I understand the 24 hour cancellation and missed appointment policy and accept responsibility for payment as described above.

_____ I hereby authorize Hope Psychology Services, LLC to release information (i.e., a statement of my diagnosis, the services I received, the name of the person providing the services, the total charges for services, and the dates of service) to my insurance carrier(s)/collectors. In addition, I understand that MB Billing Services, LLC will be provided this information in order to manage billing and insurance claims.

_____ I understand that no further information will be released without my advanced knowledge, except as authorized by law, and that access to this information will be limited to those individuals who require access to accomplish the above billing procedures. I understand that I may revoke this consent at any time and that it will expire within one year of this date or when the purpose for which it was granted has been accomplished.

_____ _____

Client or Guardian Name Telephone Number

_____ _____

Client or Guardian Signature Date

_____ _____

Person Financially Responsible for Client Account Telephone Number

_____ _____

Payor's Signature Address