Journeys Counseling Financial Policies Form

FINANCIAL POLICIES FORM

* **It is important for you to understand your insurance coverage**. For any benefit information, please call the member number on the back of your insurance card. It is your responsibility to check your plan's limitations, exclusions, co-payments and deductibles.

* In order to comply with health insurance contracts**, payments are due at the time of service or immediately following insurance claim processing**. We are not allowed to waive any co-pays, deductibles, or coinsurance amounts because this would be a violation of the contract we have with insurance providers.

* **All clients are required to have a credit card on file**. Only credit cards (no debit cards) will be allowed, so if you do not have a credit card, you are asked to pay for your services in full using whichever payment method you prefer (check, debit card, cash, and so forth) at the time of service. Credit card numbers will be kept in a secure location. If insurance later covers your bill, you will be reimbursed by Journeys Counseling.

INSURANCE/BILLING PROCEDURES:

*** If you are electing to pay privately, the entire service fee is due at the time of service.**

* It is your responsibility to provide us with the most updated insurance information. You will be responsible for any claims denied or not covered by your insurance company due to inaccurate information or lapse in coverage.

* In the case that a bill should be accrued and you are unable to pay the full amount, you may complete a payment plan agreement with your therapist. **If the payment agreement is not honored, your therapist has the right to charge any remaining fees to the credit card number provided in your file.****

* **You are responsible** for charges not eligible and/or covered by your insurance plan. If you end treatment at any time, you are responsible for the remaining portion of the bill.

* If the payment agreement is not honored and/or there is any portion of the bill that has not been paid within 60 days of ending treatment, Journeys Counseling reserves the right to turn the bill over to a collection agency. By signing this form, you are acknowledging that in this circumstance, you are waiving your right to confidentiality regarding information needed to collect the debt.

NAME:_____ DOB:_____

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COURT AND OTHER FEES NOT COVERED BY INSURANCE:

Court Appearances		*Includes travel time to and from court, time in court, and written reports required for attorneys/court. $300/hour
Report Writing		100.00 Per Report
Phone or in-person Consultation (Client, Guardian, School, Attorney, Physician consultations)		Billed in 15 Minute Increments

Late Cancellation (Less than 24 hours' notice)/No Shows: $25 for 1st missed appointment, $50 for 2nd missed appointment, Full Fee for 3rd Missed Appointment

****In the event that we would need to charge your credit card, we will notify you by email 24 hours prior to doing so. Please indicate what email address would be the best one for us to send this notification to:**

Email: _____

Client/Guardian Signature: _____

CREDIT CARD INFORMATION:

Client/Guardian Signature: _____

Type of Credit Card (Mastercard, Visa):_____

Credit Card #:_____

Expiration Date:_____CVV Code:_____

Billing Address of Primary Card Holder:

Street Address:_____

City:_____State:_____Zip:_____

NAME:
DOB: