Office Policies for Cash Pay /Reports/No Show

The patient is responsible for payment of their therapy/medication session. The patient is also responsible for understanding and knowing their insurance benefits and limits. Any questions should be asked of the insurance company.

We will contact your Health Plan carrier to verify your benefits prior to your first visit and for billing purposes. Since each insurance plan/ policy is individual we cannot be held responsible for incorrect benefits we receive from your plan. **I, _____ (enter name), authorize medical benefits to be paid to the assigned provider.**

If you are paying cash, you must pay on the day of your visit and keep your account current. We only accept cash or checks. There will be a $25.00 charge for all returned checks.

You will be charged for your visit if a No Show occurs or this office is not given a 24 hour cancellation notification. This also may result in a delay in your treatment as these fees are to be paid in full prior to your next scheduled appointment unless prior arrangements have been made with your clinician. Your responsibility for a No show/late cancel fee for a therapist is what your Health Plan would reimburse the therapist plus your co-pay. For Missed/No Show MD follow up appointments and the patient calls to request an Rx refill, enough medication will be approved only until the next appointment. You will be charged for the Missed/No show appointment for the MD which is $85.00.

There will be a $25.00 monthly fee charged every month on any outstanding balances unless prior arrangements have been made.

On a case by case basis payment arrangements/options may be established for an outstanding balance.

Reports that need to be written will be charged at a fee of $150.00- $200.00 per report. Any short forms that need to be completed will be charged at a fee of $10.00.

Any triplicates that need to be re-written due to the patient losing the triplicate, the patient will be charged a fee of $10.00.

I have read and understand the above policies and agree to comply with them and if necessary make any arrangements for those that may apply to me. Please discuss any billing matters with our biller regarding any balance on your account.

Patient signature: _____

Patient printed Name _____