FINANCIAL AGREEMENT FORM

INSURANCES:

Please check with our Billing Department to see if we participate with your insurance company. It is your responsibility to verify that we have your current address, phone number and insurance information on file.

If we participate with your insurance company, we will submit all services performed in our office for reimbursement– unless we have received prior notification of non-covered services. All copays, deductibles, or overdue balances are your responsibility and payment is expected at the time of each visit.

If we do not participate with your insurance company, you are responsible for payment in full at the time services are rendered. We will provide you with a Reimbursement Information Sheet to assist in filing your claim with your insurance company.

Insurance companies often require pre-authorization as a condition of reimbursement – whether or not we participate with them. It is your responsibility to obtain any required insurance referrals or authorizations prior to your visit. If a required referral is not presented at the time of your visit, you must sign a waiver agreeing to waive any benefits provided by your insurance company and you will be responsible for payment in full for services received. Failure to sign a waiver may result in your appointment being rescheduled.

PAYMENT FOR SERVICES

Payment for each visit is expected at the time of service. For your convenience, we accept Visa, MasterCard, cash, check, or money order. Returned checks will incur a $25 fee to each patient account affected. All patient payments including any outstanding balances are due at the time of service – unless prior arrangements have been made with the Office Manager and/or your clinician.

You will be charged for missed appointments if you fail to provide 24 hours notice. You are fully responsible for these charges because they are not covered by your insurance.

Overdue accounts may incur late fees at an 18% per annum. All balances that become 60 days past due may be sent to a professional collection agency. Should your account be sent to a collection agency, you will be financially responsible for a collection fee equal to 33 percent of the amount sent to the agency and any additional legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance. Your signature below authorizes Innersense Behavioral Health Services to release information necessary for collection of past due accounts. Payment in full of any past due balance is expected prior to being seen in our office in the future. In addition, payment in full will be expected at the time of service for any future services.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS/CONSENT TO TREATMENT

I understand that certain information may be required by third party sources for the Purpose of treatment, payment (including collections of past due accounts) and Health care operations. I hereby consent to Innersense behavioral health services releasing my health information for the purposes of treatment, payment, and Healthcare operations. I hereby assign to the practice all benefits/payments for Services rendered to my dependents and/or myself.

I understand that I am responsible for all amounts not covered by my insurance. My signature below acknowledges that I have been provided Innersense Behavioral Health services' notice of privacy Practices.

_____ _____

Printed Name of Patient Date

_____ _____

Signature of Party Financially Responsible/Parent/Guardian Date