Associated Counseling Group

♦ 748 N MAIN STREET ♦ FREMONT, NE 68025 ♦
♦ 402-941-7016 ♦

Payment Policy and Billing Practices Statement

Payment Policy:

__As with most Health Care Facilities your **Co-pay(Co-Insurance)/Office visit fee** is due at the time of service. The initial visit requires an out of pocket expense to you of *$35. Should your insurance carrier require ***pre-certification for services***, it is important to note that you will be responsible for the full session fee that is allowable by your carrier, for any sessions that occur prior to securing required certification. We will make attempts to establish what your eligibility and benefits are upon receipt of your insurance information and secure any certification that may be required, however, you as the subscriber, are ultimately responsible for your health care and for any fees incurred which your insurance does not cover in regards to pre- certification requirements deductibles, co insurance, co pays and any and all other out of pocket expenses. Until your behavioral health insurance coverage can be established or until you meet any required deductible and/or out of pocket expenses your policy may require, there will be an **Office visit fee** to be paid time of appointment of no less than $35. This fee is a portion of the session fee and the balance of the fee for each session will be billed to the insurance. Until the deductible and/or out of pocket expenses have been satisfied on the policy the balance of the session fee will then be billed to the client.

__Acceptable forms of payment are cash or check. Any check that is returned for insufficient funds will generate a charge of $35 to your patient account. Any patient account that has had a check returned on it will be placed on a cash only payment status.

__Payment plans may be an option and you and your therapist can establish what a workable amount is. Once a payment plan is established a signed agreement of this plan will be part of your patient file.

Terms:
Co-Pay/Co-Insurance- Amount of a service that your insurance carrier has determined as the subscribers liability or that the patient must pay.
Office visit fee – The portion of the session fee that is needed time of appointment until insurance is established and/or the client deductible/out of pocket amount is met or the agree upon fee for treatment when there is not insurance coverage.

I have read and understand Associated Counseling Group's **Payment Policy_____ (Please Initial)**

Billing Practices:

__It is not the practice of this office to send a **Billing Statement** unless you have a balance on your account. If your account has an outstanding balance, a billing statement will be generated submitted to you in person or via postal service. The balance is to be paid in full by the date indicated on the billing statement. Any account that generates a billing statement will include an **Account Handling or Management Fee** of $5. Any account that is not paid in full, or carries a balance from one session to the next, will generate a **Service Fee**. The service fee is 10% of the **total** balance of your account.

__An account that does not have any payment activity in any consecutive 90 day time period is subjected to referral for collection.

__This office requires **24 hours prior notification** when you are unable to keep an appointment. Missed appointments are the financial responsibility of the patient not the patient's insurance company. You will be billed the full session fee for missed appointments.

Terms:
Billing Statement- A statement of your patient payment account that is only created when you have a balance on your account.
Account Handling Management Fee - The fee for having to create and send you a billing statement.
Service Fee - The fee for extension of credit on any patient account.
24 hours prior notification – The 24 hour time period before the hour your are scheduled to meet with your therapist in which you must call the office and must leave the message either to a person or by way of voice mail message that you are unable to attend an appointment.

I have read and understand Associated Counseling Group's Billing **Policy_____ (Please Initial)**
By signing I admit and agree to the following:
I understand the Payment Policies and Billing Practices of Associated Counseling Group. I agree to the terms and condition as set forth in this statement and will follow the guidelines laid out in this statement in making payment for services.

*When your insurance coverage has been established any overpayment/underpayment will be credited/charged to your patient account.

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Client Signature and or Parent/Guardian Signature Date