

Poehailos, Dupont & Associates, PLC

SUMMARY OF FINANCIAL RESPONSIBILITY

Unless other arrangements are made, **payment for sessions is due at the time of the session** (either **full fee** if you are paying privately, or your **co-payment** if we are billing your insurance company). Fees are reflected on the **Fee Schedule**, which is included in the intake packet available on our website or in the office.

Insurance is billed as a service to our patients; however, insurance companies do not guarantee payment and if insurance payments are not received **within 90 days** of service, **responsibility for payment switches to the guarantor**. Office staff and your clinician are available to discuss payment issues with you.

Please review and initial the following:

_____ I understand that insurance may be filed for me, but that I am ultimately responsible for payment of fees regardless of insurance coverage.

_____ I authorize the release of medical information required to process insurance claims and/or to complete Treatment Plans/Reviews required by insurance or managed care companies.

_____ I authorize payment from my insurance company to be made directly to the practice.

_____ I understand that I am responsible for informing the practice of changes in my insurance.

_____ I understand that I am responsible for obtaining proper (pre)authorization from my insurance company to use mental health benefits. I accept responsibility for payment if authorization is not obtained.

_____ I understand there may be a *Report Preparation* fee involved in my clinician completing a Treatment Plan or a *Telephone Consultation* fee involved in my clinician communicating with my insurance/managed care company.

_____ I understand that most insurance companies only reimburse for face-to-face services and that I am responsible for payment of any Ancillary Services requested/utilized during the course of treatment.

_____ I understand that I may be billed for any missed appointments unless I call to cancel at least 24 hours before my scheduled appointment.

_____ I understand that mailed, monthly bills are due at the time of receipt. Any bill not paid within the month of the date of billing will have an interest charge of 1% added to the bill, unless other arrangements are made.

Signed _____

Date _____