Gold Circle Counseling
Angela Kline, PA-C

OFFICE FINANCIAL POLICY AND BILLING AGREEMENT

NAME (print)____

Insurance Coverage:

- Client agrees to contact Insurance Company to verify mental health benefits. You pay for your insurance. It is your responsibility to know the benefits of your policy._______ (initial)

- Should a dispute arise on a claim, it is generally the client's responsibility to clarify and resolve the dispute with the insurance company.________ (initial)

- If insurance is being filed, any copay is due at the time of service. _______ (initial)

- If you fail to update your insurance information with us and additional expenses are later accrued by the practice because of that, you will be responsible for those fees.______(initial)

- Fees for prior authorizations, FMLA forms, disability forms and other legal forms are not covered by insurance and are billed at a prorated hourly rate. _______(initial)

Payment:

- If insurance is not being filed, payment is expected at the time of service._______(initial)

- I agree to provide a 24 hour notice to cancel an appointment. Otherwise, late cancellation charges will be assessed up to $125. _______(initial)

- If a client does not show for a scheduled appointment, there there is a no-show charge of $125._______(initial)

- A service requested by the client, but not covered by the client's insurance plan may be arranged under separate written agreement with the provider. _______(initial)

- Phone calls and refills for controlled substances given outside of appointment times are not billable to your insurance. They are billed for the amount of professional time spent._______(initial)

- Phone calls will be responded to within 48 business hours. _______(initial)

- There is a $30.00 administration charge for checks that do not clear the bank._______(initial)

I certify that I have read, understand and agree to the foregoing. The undersigned is the client or is duly authorized by or on behalf of the client to execute the above and accept its terms.

SIGNATURE OF RESPONSIBLE PARTY_________________________________**DATE:**__________