Lora Hoffstetter and Counseling Associates, LLC

BILLING / FINANCIAL POLICIES

*Welcome to Lora Hoffstetter and Counseling Associates,LLC. We*

*are dedicated to providing you with the best possible care and service. We regard your understanding of our financial policies as an essential element of your care.*

*This information was designed to provide our clients with a detailed explanation of our financial policies.*

**Insurance Coverage**- All clients are ultimately responsible for their own bill and a clear understanding of their insurance policy. Clients who have health care coverage are responsible for providing the office with complete and accurate information regarding insurance coverage. It is the client’s responsibility, not Lora Hoffstetter and Counseling Associates, LLC to understand the terms of their insurance coverage. This includes but is not limited to: knowing what services are covered, that their provider is in network, their deductible, co-payment, co-insurance (if applicable), and obtaining required referrals. If LHCA does not have an existing contract with a client’s insurance plan, the client will be responsible for the full billed amount. Clients remain primarily liable for payment of all behavioral services which are not covered by their insurance. \_\_\_\_\_\_\_\_ (Initial)

**Self-Pay clients-** Clients without health coverage are expected to pay their bill in full at time of service. \_\_\_\_\_\_\_ (Initial)

**Co-Pays-** Any co-payments required by your insurance company are due at the time of service! \_\_\_\_\_\_\_\_ (Initial)

**Financial Responsibilities-** I understand that I am financially responsible for the cost of the psychological services or any portion of the fees not reimbursed by my health insurance. If my mental health care is provided under the terms and conditions of a managed health care program, which the Clinician is contracted, my financial responsibility may be limited to the terms of the contract. If my balance is over $50.00 I must make payment arrangements with the office staff prior to future appointments being made. Failure to pay these bills may result in collection procedures (including court proceedings) being taken against me by LHCA or a collection agency contracted by same to collect these bills. I also understand that I will be responsible for any additional charges incurred through the use of a collection agency contracted by LHCA to collect these bills. I also understand that I will be responsible for fees incurred through the use of a collection agency or the filing of a court action including attorney and filing costs. \_\_\_\_\_\_\_ (Initial)

**Credit Card Authorization:** I understand that LHCA requires all clients to provide their credit/debit card information on file so co-payments, co-insurances, deductible amounts, cancellation and missed appointment payments, and all other professional service charges will be automatically charged. A Credit Card Authorization form will be given to me prior to my first appointment.

\_\_\_\_\_\_ (Initial)

**Medicare/Medicaid Policy-**  Lora Hoffstetter and Counseling Associates, LLC does not accept any Medicare or Medicaid products. \_\_\_\_\_\_\_\_ (Initial)

**Referrals-** If your insurance policy requires a referral, it is your responsibility to see that a referral is obtained and to provide that referral to our office. If authorization is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service. \_\_\_\_\_\_ (Initial)

**Check Returned for Insufficient Funds-**  There is a $20.00 fee for checks returned for insufficient funds. \_\_\_\_\_\_\_ (Initial)

**Notice of Balance on Account-**  In an effort to reduce the cost of mailing billing statements we will notify you of your balance due at time of service. This is only a notification of the balance on your account & gives you the opportunity to pay on the account while you are in the office. Balances over $50.00 must be paid in full prior to your session or we will need to reschedule. \_\_\_\_\_\_\_ (Initial)

**Missed Appointments-** We understand that occasionally a client may run into a situation where they cannot make their appointment. We ask that you call to cancel your appointment at least 24 hours of your scheduled time which allows us the ability to use that time for another client. Failure to call and cancel your appointment within the appropriate amount of time may result in a cancellation charge of $75.00. If you need to cancel after the office is closed, please leave a detailed voicemail message. If there are subsequent missed appointments, you may lose your ability to schedule future appointments or may be referred to another facility. \_\_\_\_\_\_\_ (Initial)

**Fees and Services Provided-** Charges for services provided are subject to change without notice. Each client’s insurance coverage and financial situation is different. If a client has a concern regarding what our charge for a service is, it is their responsibility to ask prior to the service being performed. We can provide you with a copy of our office Fee Schedule. This includes services such as: mental health assessments, treatment summaries, report writing, telephone calls that are more than 10 min in length, and any legal proceedings. \_\_\_\_\_\_\_ (Initial)

**Completion of forms-** The therapists are often asked to complete a variety of forms outside of a client’s visit. This requires time from the therapists’ day to review the chart and complete the forms accurately. Therefore, we do charge a flat fee of $20.00 for this service which must be paid prior to the forms being filled out. \_\_\_\_\_\_\_ (Initial)

**Medical Records Fee**- We are willing to assist clients who request copies of their records. Due to the time and printing involved, there will be a fee of .50 cents per page. If additional copies of the record are requested there will be a fee of $15.00 per request. (Fee is subject to change)

\_\_\_\_\_\_ (Initial)

**Minor Clients-** All minors attending sessions without a parent are advised to bring their copay to their appointment. If they do not have the copay, they may be asked to reschedule and charged a $75.00 cancellation fee \_\_\_\_\_\_\_ (Initial)

**Parental responsibility-** The parent or legal guardian that presents the minor for care and authorizes treatment will be the one who receives the bill for services provided and is responsible to see that the balance is paid. If you have an arrangement that is different than this, please advise the front desk. \*You may be asked to provide documentation regarding financial responsibility.

\_\_\_\_\_\_\_ (Initial)

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Client or Parent/Guardian Signature Date