**Associates in Psychology & Therapy, Inc. (APT, Inc.)**



**East Hills Professional Center**

**5185 Route 60 East, Suite 32**

**Huntington, WV 25705**

**www.wvpsychologist.com**

**PH: (304) 302-0526 Fax: (304) 302-0527**

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| **Client Financial Agreement** |

**Name:**  **Date:**

**Date of Birth:**

**Fees**

Fees at Associates in Psychology & Therapy, Inc. (APT, Inc.) are based on the length and type of treatment. You will be responsible for the charges not covered. Fees are available upon request.

**Self-Pay Accounts**

We designate accounts, Self-Pay, under the following circumstances:

* + 1. client is covered by an insurance plan that our providers do not participate in,
		2. client does not have a current, valid insurance on file,
		3. client does not have a valid insurance referral on file, or
		4. client does not have health insurance coverage.

**Payment is Due at the Time of Service**

* We accept cash, checks, debit, and credit cards.
* All co-payments, deductibles and non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment.
* Insurance required co-payments are due when you check in for your appointment. If you arrive without your co-payment, we may ask you to reschedule.
* If our co-payment is based on a percentage (example 20% of the allowed payment) and you do not have a secondary policy, please be prepared to pay a minimum of $40.00 on the date of service.
* Client responsible balances are due when you check in for your appointment.
* If your child comes for an office visit without a parent, you are still responsible for the co-payment at the time of service.
* If we cannot verify your insurance coverage at the time of your visit, we require a minimum of $50.00 deposit per visit.
* It is your responsibility to understand any deductibles that may apply to you under your insurance policy. Our billing department will send you a statement of the amount your insurance company has determined is applied to your deducible and is owed by you. Not paying deductibles is considered insurance fraud.
* If your check is returned a $25.00 returned check fee will be assessed.

**Insurance**

Health insurance is a contract between you and your insurance company. Signing this form verifies that you understand there is no guarantee of payment from any insurance company or other payer. APT, Inc. makes NO guarantee of any estimated coverage since the insurance policy is an agreement between you and your insurance company.

* As a courtesy to our clients we file your insurance at no charge if you provide all insurance information. It is your responsibility to ensure that we have accurate insurance information. Presenting an invalid or inactive insurance card will result in full payment by you.
* Medical insurance does not always cover the entire cost of your mental health care. If we believe a service we offer is not covered by your insurance coverage, we will tell you. In some instances, however we do not learn that a service is not covered until after we submit a bill. You are responsible for payment if your insurance company refuses to pay for a service rendered by an APT, Inc. provider.
* It is our obligation under many of the insurance contracts to report clients who: repeatedly refuse to pay co-payments/deductibles at the time of service, or who repeatedly “no show” for appointments. We reserve the right to bill the client for no shows or cancellations with less than 24 hour notice with a fee of $50.

**Pre-Authorization Requirements**

The client accepts the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which you are relying for medical coverage of Associates in Psychology & Therapy, Inc. (APT, Inc) charges.

**Assignment for Direct Payment**

Client authorizes that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to Associates in Psychology & Therapy, Inc. (APT, Inc.).

**Cancellations and No Shows**

Signing this form verifies that you understand that 24 hour notice is required for canceling an appointment, and you will be charged a $50 fee for any missed appointment without required notification. You also understand that you alone will be responsible for this charge and that you insurance company will not be billed for that day. After two No Shows/Late Cancels, client will be discharged from our services; we can provide a list of alternative providers on request.

**Divorce and Child Custody Cases**

* In cases of divorce, the individual who receives care is responsible for payment of co-payments, coinsurance, deductibles and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the client's services.
* The parent who brings the child to the office for care is responsible for payment at the time of service no matter if the account is self-pay, participating insurance, or nonparticipating insurance. APT, Inc. does not honor divorce specifics (e.g., percentage of financial responsibility). If the child has coverage with a participating insurance plan and the proper insurance and identification is present at the time of service, the practice will bill that insurance company.

**Billing, Payments, and Refunds**

* All balances are due in full within 30 days of the statement date.
* If you cannot pay the balance in full within 30 days, please contact our office to see if you qualify for special payment options.
* It is your responsibility to notify the office of any changes in address, phone, employment or insurance coverage.
* If you make an overpayment on your account, we will issue a refund only if there are no others outstanding debts on other accounts with the same guarantor or financial responsible party.
* Refunds will be issued when treatment has ended.

**I am financially responsible for this account** with Associates in Psychology & Therapy, Inc. (APT, Inc.) and **agree to the above terms.** I agree to pay all charges for the services provided by Associates in Psychology & Therapy, Inc. (APT, Inc) which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If payment is not made within 90 days from the date the bill was mailed from Associates in Psychology & Therapy, Inc. (APT, Inc.), I understand that a delinquent charge of interest rate of 18% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Associates in Psychology & Therapy, Inc. (APT, Inc.).

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Signature of Patient or Legally Responsible PersonName (Please print)

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Relationship/Reason Why Patient Is Unable to Sign Date

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Witness Date