MEANINGFUL CONNECTIONS COUNSELING, PLC

FINANCIAL POLICY

Payment Agreements

- I understand that payment is required at the time services are rendered unless payment arrangements have otherwise been made.
- I understand that I am responsible for the cost of all diagnostic and treatment services not covered by my insurance carrier unless otherwise indicated by my managed care contract.
- I understand that I am required to notify my therapist of any changes in my insurance coverage and/or carrier before the next session following the change.
- I understand that as the parent or guardian of a minor receiving therapy or testing services from a Meaningful Connections Counseling provider that I am responsible for full payment.
- I understand that Meaningful Connections Counseling has a no show policy. I understand that it is the policy of Meaningful Connections Counseling to charge and collect $50.00 for each missed appointment, or cancellation with less than 24 hours notice, in accordance with this policy. I understand it is my responsibility to make this payment on or before my next appointment, and that insurance does not cover this fee.
- I understand that my therapist may elect to terminate clinical services if I fail to meet my financial obligations as defined by this Financial Policy.
- I acknowledge that I have read and understand all of the terms of this Financial Policy, and I understand that failure to pay any applicable fees may result in collection actions. I understand that outstanding balances of more than 90 days will incur a monthly service fee until paid in full. The monthly service fees are as follows: $5.00 fee for balances of $99.99 or less, $10.00 fee for balances of $100.00-$249.99, $25.00 fee for balances in excess of $250.00. I understand that I will be responsible for any and all collection fees incurred by Meaningful Connections Counseling in the effort to collect the debt, including court costs.
- I authorize Meaningful Connections Counseling to provide to its billing agency whatever insurance, demographic and diagnostic data is reasonable and necessary to obtain payment from the insurance carrier or responsible party, for the duration of services rendered to myself or my child, as well as following termination of services until payment has been made in full.

Signature____ Date_________________

(Responsible Party)

Witness____Date________________

(Provider)