Integrity Counseling, LLC

HIPAA

I, _____ ACTING ON MY OWN BEHALF, OR ON THE BEHALF OF A MINOR CHILD (UNDER THE AGE OF 14), OF WHOM I HAVE LEGAL CUSTODY, DO HEREBY GIVE PERMISSION AND AUTHORITY TO, INTEGRITY COUNSELING, LLC, TO DISCUSS MY BILL/STATEMENT WITH ONLY THE PERSON OR PERSONS LISTED BELOW, REGARDLESS OF WHO MAKES PAYMENT ON THIS ACCOUNT.

Name	**Telephone #**	**Relationship**	**Purpose we can communicate**
			BILL/STATEMENTS
			BILL/STATEMENTS
			BILL/STATEMENTS
			BILL/STATEMENTS
			BILL/STATEMENTS
			BILL/STATEMENTS

THIS AUTHORIZATION IS IN EFFECT UNTIL I REVOKE IT.

Client Signature _____ DATE:_____

Parent/Guardian Sig. _____ DATE:_____

Appleton Office
1047 N Lynndale Drive Suite 2B
Appleton, WI 54914
(920) 385-1420
office@integritycounselingllc.net

Seymour Address:
225 S Main St, Suite 3
Seymour, WI 54165
(920) 385-1420

Mailing Address:
P.O. Box 282, Black Creek, WI 54106

Oshkosh Office
404 N Main St, Suite 612
Oshkosh, WI 54901
(920) 385-1420
www.integritycounselingllc.net

Payment Policy

Thank you for choosing Integrity Counseling LLC. We are committed to providing you with quality and affordable services. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. Proof of insurance. All patients must complete our patient information form before seeing their counselor and provide us with an up to date copy of your insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. Nonpayment. If your account is over 90 days past due or your balance exceeds $250 you will not be able to schedule another appointment until appropriate payment arrangements are made.
8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

_____

Responsible Party Signature/Date ☐ I have read and understand the payment policy and agree to abide by its guidelines