Financial Policy and Agreement
Confidential Care

Thank you for choosing Confidential Care for your mental health care.

Clients with Insurance

It is important for you to verify and understand your insurance policy requirements, limitations, and what your insurance offers for mental health benefits so that you understand your coverage prior to your appointment. You will be responsible for care not covered by your insurance plan. You are required to pay any co-payment amount at the time of service. Additionally, you are responsible for the timely payment of your account.

If we are listed by your insurance company as being a preferred provider or 'in-network', our billing department will send your claim directly to your insurance company for processing on your behalf. If your insurance company fails to pay Confidential Care within a reasonable time of 60 days or less or pays only a portion of the bill, you are responsible for payment of the remaining balance.

If we are **not** listed by your insurance company as being a preferred provider, or your insurance company does not reimburse providers who are 'out-of-network', the client will need to pay the full amount due for services rendered on the day the service was provided. The client will be given a 'superbill' to mail off to their insurance company's claims department. This 'superbill' will have all of the necessary information needed for your insurance company to process your claim. Any reimbursement from the insurance company will be sent directly to you, the client and not to Confidential Care.

No Show/Late Cancel

Failure to provide a 24-hour notice to cancel your appointment or 'no show' deprives other clients from receiving mental health care. A 'No-Show' or cancellation of an appointment less than 24 hours will be charged a late cancel/no show fee, and insurance companies do not pay charges for missed appointments. Special consideration will be made for illness or extremely poor weather conditions/road hazards.

Statements

If our billing department sends your claim directly to your insurance company, you will receive a monthly statement from us for any remaining balance after your insurance processes your claim. Billing statements will go out monthly and all patient balances are due within 20 days of our statement date.

Payment

You could make a payment to Confidential Care by mail at the address located on your statement, by calling 907.357.1999 during business hours, or you could pay in person. We accept cash, check, and all major credit cards. Please note that a $ 35.00 fee will be added to your account for any checks that are returned from the bank due to insufficient funds.

Refunds

Refunds for credits on your account will be made to you or your health plan or insurance company, by check, to the address we have on file. Refunds may take up to four weeks to process.

Self-Pay Clients

- All cash clients and clients that present without valid insurance information are considered a Self-Pay Client.
- All Self-Pay clients are required to pay at the time service is rendered.
- A 20% discount is applied to all self-pay clients
- Please be prepared to make this payment with the front desk personnel prior to being seen by clinical staff.

Payment Plan

Arrangements can be made if you are unable to meet your financial obligations. However, ***you*** will need to contact the billing office at 907-357-1999 to set up the agreement within 20 days of your first statement date. We offer interest free monthly payment plans unless legal action has occurred on an outstanding balance. Refer to Confidential Care's Payment Plan Agreement for further details.

Collections for Unpaid Balance

If fees for services are not paid in a reasonable amount of time of 60 days, and attempts have been made to resolve the financial matter to no avail, your account will be sent to a collection service. You will be responsible for any additional fees to cover the cost of the collection and/or any court costs incurred. This fee will be added to your outstanding balance.

In the event that your account is sent to a collection agency, Confidential Care will no longer send you monthly billing statements, instead you will be working with the collection agency that we contract with to oversee delinquent accounts, initiate the legal action, and to report all unpaid debt to the major credit reporting agencies. In addition, all future appointments will be cancelled and you will be given a referral list of community mental health providers to seek care. We will render care for urgent matters only for the next 30 days. Beyond this date no care will be rendered.

Questions

We know that you will agree that your clear understanding of our financial policy is important to our professional relationship. Our office staff is always willing and available to discuss insurance and billing matters with you at any time. Please don't hesitate to ask us if you have any questions pertaining to our financial policy and agreement.

Ψ Print Name: _____

Financial Policy & Agreement

Confidential Care

If you have any questions or need clarification on anything that you do not understand please ask us before initialing the following terms of the Financial Policy and Agreement.

_____I consent to treatment by the providers of Confidential Care.

_____I understand that I am responsible for knowing my insurance policy requirements, limitations, and mental health benefits and that I will be responsible for care not covered by my insurance plan.

_____I authorize the release of pertinent medical information to insurance carriers.

_____I authorize my insurance benefits be paid directly to Confidential Care unless I have paid out-of-pocket for services and will be submitting my own claim through my insurance carrier for reimbursement.

_____I understand that if I will be submitting my own insurance claim, my provider will provide the necessary information needed on my superbill so that I could attach it to my insurance claim form before sending it to my insurance company for processing.

_____I understand that I will be financially responsible for all treatment fees if I fail to keep Confidential Care informed in writing of changes in my insurance.

_____I understand that I am obligated to pay co-payments, co-insurances, and deductibles as required by my health insurance.

I accept responsibility for the payment of all non-covered services to include:

_____Less than 24 notice of cancellation/no show fee ($100.00 therapist and $200.00 for medication provider)

_____Non-sufficient fund fee ($35.00) for returned checks

_____I understand that any outstanding balance will be turned over to a collection agency if the balance on my account is not paid within 60 days.

_____I understand that billing services will cease from Confidential Care should my account become delinquent [A delinquent account is any account that has a posted charge that has not paid in full within 60 days of the date that I was first notified on my billing statement] and instead I will be working with a collection agency who oversees delinquent accounts.

_____ I understand that the collection agency will report all unpaid debt to the major credit reporting agencies and can initiate legal action to collect payment on a delinquent account if necessary.

_____ I understand that any fees and costs will be added to my account to cover the cost of collection and that I will be responsible for these and any court costs incurred.

_____I understand that should my account become delinquent, all future appointments will be cancelled and I will be given a referral list of community mental health providers to seek care. Additionally Confidential Care will only render care to me for the next 30 days for urgent matters only. Beyond 30 days no care will be rendered.

My signature below indicates that I have carefully read the Financial Policy and Agreement, understand and accept the terms of this agreement, and agree to the my financial responsibility set forth in this agreement.

_____ _____

Signature Date