Center for Psychological Health and Wellness, LLC
Dr. Heidi Ramsbottom, PhD
Dr. Nancy Bailey, PhD, CAADC, CCDP/D
122 W. Lancaster Ave., Suite 206, Shillington, PA 19607

Financial /Office Policy
Effective: June 1, 2021

Center for Psychological Health and Wellness (CPHW) will implement a new policy requiring all patients to provide a credit card on file, effective January 1, 2020. As you may be aware the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured. Some insurance plans require high deductibles and copayments in amounts not known to you or us at the time of your visit.

Similar to many other businesses, including healthcare practices, you are required to provide your credit card number at the time of making an appointment. Our Credit Card on File Policy allows CPHW to easily process time of service payments, deductibles (if applicable), and copayments. In addition, your credit card will be charged if your appointment is cancelled outside our specified timeframe as outlined in our Late Cancellation Policy. You will be advised of this charge and a receipt will be provided as requested.

Center for Psychological Health and Wellness will store our Credit Care on File in secure electronic form within our EMR system.

AUTHORIZATION:

I authorize Center for Psychological Health and Wellness to charge all balances applied to co-pay's, deductibles, denied for non-payment of insurance premiums, or late cancellation fees for the following patient(s): _____
Last 4 digits of credit card: _____ **Expiration Date**: _____
I understand that once my health insurance has processed my or my dependent's claim, I will receive an Explanation of Benefits (EOB). The EOB will show any balances due that are patient responsibility. I agree that Center for Psychological Health and Wellness may charge my credit card on file for the balance due when they receive the EOB from my health plan. If the balance due is more than $200.00, I will receive a courtesy call prior to my card being charged. I further understand that if payment is denied by the credit card on file, I will not be able to schedule any further appointments until the balance is paid in full.

Signature: _____

Appointment Reminders:

Please note that effective with 2020 appointments, CPHW will now send **reminders of upcoming appointments 48 hours in advance**. This change is being made to assist patients with planning and to reduce late cancellation fees to patients. Our hope is that 48 hours notice provides patients with more time to contact us to change appointments or to make changes in order to attend.

Late Cancellation / No-Show Policy:

- We value the time we have set aside to see you for your appointment and consistent attendance at regular meetings is critical to the care we provide. If you are unable to keep an appointment, we require a minimum of **24 hours advance notice of cancellation** (unless we both agree that you were unable to attend due to circumstances beyond your control). Monday appointments need to be cancelled by 5pm Friday. If the required notice is not received or you do not show for an appointment, a late cancellation fee applies as follows: **First time cancellation will be assessed a fee of $75, second time cancellation will be assessed a fee of $150.** If you miss or cancel two or more sessions within a two-month period, we reserve the right to offer the designated time to another client. Depending on the circumstances, we reserve the right to discontinue or end our professional relationship.

Initial: _____

Appointments:

- One appointment hour is usually 40-53 minutes in length depending upon timeframes designated by your insurance.
- We ask that you be on time for your scheduled appointment. If you are late, we will probably be unable to meet for the full time, because it is likely that we will have another appointment scheduled to occur after yours. **We will only hold your scheduled appointment time for 15 minutes. After that, your appointment will be cancelled and a fee will be charged in accordance with our late cancellation policy.**

Initial: _____

Insurance Plans:

- It is your responsibility to keep us updated with your correct insurance information. Upon arrival we ask that you come prepared to present your insurance card at each visit if requested.
- It is your responsibility to check with your insurance company to determine if services provided by our office will be covered under your insurance plan.
- If your insurance plan does not cover services with CPHW, you are responsible for payment of the visit. CPHW is not responsible to determine your specific insurance plans coverage.

Initial: _____

Financial Responsibilities:

- Payment for services is expected at each session. YOU, not your insurance company, are responsible for payment in full unless your CPHW therapist/ psychologist has a contract with your insurance company to provide care at a pre-agreed fee. If you participate with one of the insurance companies contracted with one of our staff members, please note that only deductibles or copayments are due at the time services are provided.
- Payments for other professional services will be agreed upon when they are requested.
- Phone contact or email contact charges are due at the time of the next face to face meeting of by charge to your credit card on file. Please understand that it typically requires extensive time for CPHW psychologists/clinicians to review written materials sent via text or secure email through the Therapy Appointment portal.
- If your account has not been paid by you or your insurance for more than 60 days and arrangements have not been made to repay, we have the option of using legal means to secure payment. Legal methods of collection may involve use of a collection agency or small claims court. If such action is needed, its costs will be included. CPHW may terminate services for non-payment of fees.
- We accept cash, check and major credit cards for payment.
- Returned checks will result in a charge of $25 plus all bank fees.

Initial: _____

Additional Fees:

- Letter writing, consultations with other professionals (e.g. school, physicians, attorneys, etc.), doctor consultations, or conversations with you over the phone or email (for purposes other than scheduling an appointment or arranging payments) will be charged a rate of $50 per quarter hour of service. Conversations lasting less than 5 minutes will not be charged.
- If you become involved in legal proceedings that require our participation, you will be expected to pay for professional time even if we are called to testify for another party. The charges pertain to preparation time, travel time, and associated costs, waiting time and transportation costs. Because of the difficulty of legal involvement, we charge $400 per hour and a $1000 retainer is required in advance.

Initial: _____

Contacting Us:

- We are often not immediately available by phone, text, or email. While we are generally in the office from 9:00a.m. to 5:00p.m., we will not answer the phone when we are with clients. When we are unavailable our phone is answered by voicemail which is monitored frequently. We will make every effort to return your call on the same day you make it with the exception of weekends and holidays.
- Our office does accept text messages. Please reserve text messaging to discuss appointment changes ONLY. Confidential information is not to communicated through text messaging.
- For all confidential information please call our office. If your phone call is not answered, you may leave the information on our voicemail during business hours.
- In order to protect your privacy, when emailing information, please use the email associated with your *Therapy Appointment* account. We will no longer be accepting emails sent outside of the *Therapy Appointment* system.
- **As always, in an emergency, please proceed to the nearest emergency room or call 911.**

Initial: _____

Please note: The above information is only a summary of policies for our office. For more detailed information, please refer to our document "Information for Clients".

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined in this document.

Patient Name: (list all individuals that are clients with CPHW)

_____ D.O.B _____

_____ D.O.B _____

_____ D.O.B _____

_____ D.O.B _____

_____ D.O.B _____

Responsible party name: _____ **Relationship**: _____

Responsible party's signature: _____ **Date**: _____