PAYMENT POLICY

Thank you for choosing Clinical Behavior Analysis (CBA) as your primary Applied Behavior Analysis (ABA) provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed 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 commercial insurance plans, Kentucky Managed Care & Medicaid Waivers. If you are not insured by an insurance carrier we participate with (in-network), payment in full is expected at each visit. If you are insured by a plan we are in-network 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 ABA coverage. CBA will also verify your eligibility and copay/cost share responsibilities before services are rendered. Some coverage is mandated by Kentucky, but not all.
2. **Co-payments and deductibles.** All copayments 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 copayments and deductibles from patients can be considered fraud. Please help us follow your insurance carrier's rules and regulations by paying your copayment, cost share or deductible responsibility per session provided. .
3. **Authorization for Credit/Debit Card Payments.** As part of our intake paperwork, you are required to complete the Authorization Form for Credit/Debit Card Payment. This form gives consent for CBA to charge your credit/debit card for copays, cost shares, subscriber fees or deductibles per the subscriber's insurance plan. You have the following options for payment. Please initial next to the option that works best for you.
    1) _____ Copay per session. You will be charged for any copays after the session is provided on the following Friday and a receipt will be sent to you.
    2) _____ Cost-Share per month. You will be charged for any subscriber fees (cost shares or deductibles) that have occurred for the month. Monthly charges will occur around the 5th business day of each month and a receipt of payment will be sent to you.
    3) _____ Pay a retainer: To cover your contracted financial responsibilities (i.e., copayments, cost shares and deductibles) that occur for any services provided; retainer deposits start at 50% of your current deductible and may go up based on your insurance coverage (i.e., $1000 deductible equals a $500 required retainer deposit). Before services can begin I agree to provide a 50% deductible retainer.
    4) _____ I do not want to be financially responsible for CBA's services.

- If no sessions are provided then no charges are made to your account. Charges are made based on your copayment, cost share or deductible responsibility, according to your insurance policy (this info. can be provided to you by CBA or your insurance company). CBA verifies your agreed financial responsibilities through your insurance company.

4. **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 your Insurance. You will be billed in full for these services according to your insurance policy although we will verify your benefits and eligibility before services are provided with the insurance carrier info. you provide. We strive to minimize or eliminate any charges to you, and expect that you will know your policy and payment responsibilities.
5. **Proof of insurance.** All patients must complete our Insurance Reimbursement Form (IRF) before seeing the ABA professional. We must obtain a copy of your driver's license and current valid insurance (front and back of card) to provide proof of insurance. 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.
6. **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.
7. **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. CBA will then reimburse you for any payments your insurance makes on that claim.
8. **Nonpayment.** If your account is over 30 days past due, you will receive a letter stating that you have 15 business days to pay your account in full or find another provider before possible discharge from the agency. Partial payments will not be accepted unless otherwise negotiated (if you would like to have a payment plan, contact the office immediately). Please be aware that if a balance remains unpaid, we will refer your account to a collection agency.
9. **Missed appointments.** Our policy is to charge $25.00 for missed appointments not canceled within 24 hours advanced notice. 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 services to our participants. 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.

I have read and understand the payment policy and agree to abide by its guidelines:

_____
Printed Name of Patient

_____
Printed Name of Responsible Party (if different from above)

_____ _____
Signature of Patient or Responsible Party Date