FINANCIAL AGREEMENT

I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family where I am listed as the responsible party. I hereby agree to pay my insurance deductible and/or co-payment as services are provided. If for any reason there is a balance due on my account, I agree to pay promptly upon receipt of the monthly statement. It is also my responsibility to review the Explanation of Benefit (EOB) forms I receive from my insurance so I can track insurance payment for services rendered. I understand that my insurance claims will typically be sent electronically via computer modem to claims processing clearinghouse. This clearinghouse will direct the insurance claim to my insurance company electronically where it will be reviewed by any insurance company staff assigned to review claims. I understand that my insurance company will obtain information listed on the insurance claim about my diagnosis and the dates of my mental health treatment sessions.

By my signature below, and as recorded on the HIPAA consent form, I am giving BASICS Group Practice, LLC permission to release all data necessary to my insurance company to determine eligibility and to process my insurance claim electronically. I realize that my insurance company may choose to make this information available to other entities, including other insurance companies. Furthermore, I authorize that payment of mental health benefits be made to BASICS Group Practice, LLC. Any questions that I have about confidentiality can be answered in the Notice of Privacy Practices found in the office waiting room and made available to all clients. I have also signed the HIPAA acknowledgement form and understand my client rights and the rules regarding release of Protected Health Information. I have been informed that I can ask the Privacy Officer any questions regarding confidentiality of records, the complaint procedure, or other matters pertaining to my review of my record.

Although I have requested the office to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

*Certain special services (e.g. school psychological evaluations, report writing, some types of testing, court-ordered treatment/evaluation) are often not covered by insurance. It is the client's responsibility to determine what services are and are not covered by their health insurance.

If you are being seen for any services other than psychotherapy (e.g., psychological testing), it is strongly recommended you call your insurance carrier to verify coverage.

If you become involved in any legal matter that requires your therapist to testify in Court, or to prepare reports for your attorney or the Court, you will be charged $200.00 per hour for these special services. These services will not be billed to insurance as they are not mental health therapy/evaluation services. YOU WILL NOT NECESSARILY BE REMINDED OF THESE SPECIAL CHARGES.

INITIAL HERE

FINANCIAL AGREEMENT

I understand that charges will be added to my account for professional services rendered by my therapist (i.e., phone contacts over 5 minutes, preparation of special forms, reports, court time, etc.).

For Court-ordered Custody Evaluations the fee is $250.00 per hour for all services.

I am also aware that I will be charged $75.00 for each appointment that I miss or cancel less than 24 hours in advance. I agree to pay this amount and I understand that this charge cannot be billed to my health insurance carrier.

INITIAL HERE ☐

I have read and understand the financial agreement as detailed above. By my signature below I agree to abide by the terms of the financial agreement, fully understand the release of information to my insurance carrier, and agree to make all efforts to pay for services rendered in a timely fashion. I am signing this agreement prior to receiving any professional services and understand that should I choose not to proceed with my initial session due to my finding the terms of this agreement unacceptable. I will not be charged for the canceled session. If I do not pay my outstanding balance for three (3) consecutive billing cycles my account will be turned over to collections.

Your signature below indicates that you have read the information in this document, that you have understood it, and that you agree to abide by its terms.

Client Printed Name

Client Signature **Date**

Parent/Guardian Signature (If Client Under 18 Years) **Date**

Clinician Signature **Date**

BASICS
COUNSELING & TESTING
A DIVISION OF BASICS GROUP PRACTICE, LLC

301.420.1972 | info@basicscounseling.com
7610 Pennsylvania Avenue, Suite 203
Forestville, MD 20747

FINANCIAL AGREEMENT

ADDENDUM

This brief addendum to our Office Financial Policy is to remind you that as a new client to our office it is very important each time you see your therapist for professional services that you pay your insurance co-payment amount (the amount your insurance policy says you must pay each time), or your self-pay amount (the amount clients without insurance pay), in the form of cash/credit card. If the client is a minor, or adult under guardianship, it is important that the client's parent or guardian make sure they come to each session with the proper payment for services. If the client comes alone, the parent or guardian must make arrangements for payment to be made at the time of the session. Failure to bring your proper payment to each session may result in you not being seen by your therapist that day, and your session may be re-scheduled. This decision is at the discretion of your assigned therapist.

All clients being seen via telehealth services are similarly responsible for making any payments prior to the scheduled session via your online portal, MYIO. Remember, regardless of your insurance coverage, you are ultimately responsible for the balance of your account for the professional services rendered. For this reason, it is VERY important that you track how much your insurance is paying for services. It is also necessary for you to know what your insurance coverage is. ***We check your benefits as a courtesy to you, but you are ultimately responsible for checking on and knowing what your coverage is.***

If your insurance reaches the yearly maximum, or does not cover certain services, you are responsible for tracking that and paying the balance. You can track this by paying close attention to the Explanation Of Benefits (EOB) form that your insurance company will send you.

A bill will be sent every month to clients who owe the Practice money for their portion of the charges. We ask that you make sure at the time of service that you pay any deductible, co-pay, or outstanding balance in order to avoid the extra work and cost of sending out bills or reaching you by phone. We reserve the right to charge interest at the rate of 1.5% per month on all outstanding balances.

If your insurance company denies payment for any services, that amount will be transferred to your balance.

Should your address, name, other identifying information, or insurance coverage change please be aware that it is the responsibility of the client to inform our office immediately.

INITIAL HERE

FINANCIAL AGREEMENT

ADDENDUM (CONTINUED)

By way of my signature, I am agreeing to the BASICS Group Practice, LLC financial policy as described above We will be glad to continue to deal with the insurance company on your behalf, but you will be responsible for any unpaid charges. We submit insurance claims as a courtesy to you, but it is ultimately your responsibility to know your benefit limits and to obtain payment from your insurance carrier. We need to work together to ensure your insurance carrier pays their fair portion of your bill for services. Remember, you can use a credit card to pay for any services rendered at our office either in person or online through MYIO. We sincerely appreciate your cooperation in helping us keep your account balance paid in full as you receive professional services at BASICS Group Practice, LLC.

Your signature below indicates that you have read the information in this document, that you have understood it, and that you agree to abide by its terms.

Client Printed Name

Client Signature **Date**

Parent/Guardian Signature (If Client Under 18 Years) **Date**

Clinician Signature **Date**

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CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy): _____ CVV Code: _____
Street Address:_____ Cardholder ZIP Code: _____
Email Addres:_____ Phone: _____

I authorize BASICS Group Practice, LLC to charge my credit card for the amount below:

_____ cost of the entire therapy session, or
_____ insurance co-pay or deductible
amountI understand that my information will be saved to file for future transactions on my account.

_____ _____
Customer Signature Date

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