HopeSprings Counseling Services

Fee Agreement and Financial Policy

Client Name: ___________________________________ Date: ______________________

Fee Agreement and Financial Policy ☐Not Applicable (EAP Only)

This contains important information regarding fees and insurance. Please review and make sure you understand the policy. If you have any questions, please discuss with the Intake & Accounts Receivable Specialist or the Program Assistant BEFORE signing.

Fees: HopeSprings offers a wide variety of services. All services are provided by a professional and billed accordingly. Copays and other out of pocket expenses are due at the time of service.

Health Insurance: As a courtesy Hope Springs will submit claim information to your insurance provider, if applicable, to help assist with the cost of treatment.

Client Responsibility for Payment: In general, clients are responsible for payment at the time of service.

- If insurance is being used, ALL co-pays, deductibles and/or co-insurances (if known) are due at the time of service.
- If Medicaid is being used, any spenddown fees, if applicable, are due at the time of service.
- If insurance or Medicaid does not cover services provided, you are responsible for full payment at the time of service.
- If you cannot pay for the services at the time of your appointment, you may not be seen.
- Accepted forms of payment are cash or check. Checks should be made payable to Cunningham Children's Home.
- If services are paid by check and returned due to non sufficient funds, a $25 fee will be charged in addition to the amount owed for services.

Private Pay: If you do not have insurance or other benefits, you will be required to pay full price for one session. You may request the sliding scale application from the Program Assistant.

_______Cancellations and Missed Appointments: Insurance companies and Medicaid do not pay for missed or cancelled appointments. Cancelations require at least 24 hour notice by phone. If we are closed or otherwise unavailable, leave a confidential voice mail to cancel. If an appointment is canceled or missed without the appropriate notice, you will be charged $25.00.

_______ Late Cancellations: HopeSprings understands that illnesses and emergencies happen. Each client will be gifted one free late cancellation per calendar year. In order for the free late cancel to be applied, you must inform us at the time of cancellation of appointment. For all other cancellations, you will be charged a $25.00 late cancellation fee (this is discounted from our usual hourly rate of $150.00)

._______No Shows: If you do not show up for your scheduled appointment and do not provide a minimum of 24 hour notice you will be charged a $25.00 fee, no exceptions. We are not like a doctor's office where we schedule multiple

people an hour knowing some may not show up. Our providers set aside one hour specifically to see you. It is not acceptable to no show your appointments.

_______Past Due Accounts: If you do not pay for services on time, you may have services terminated. All past due accounts will be assessed a $25.00 penalty if payment has not been received within 30 days. All clients may request a payment plan. Clients have 10 business days to agree to a payment plan or pay balance in full once notified their account is past due. If the balance remains unpaid or a payment plan has not been established in the appropriate time frame, the client will be notified by mail that services are being terminated as of the effective date of the letter. Accounts with a balance of $50.00 must reduce their balance to $0 or set-up a payment arrangement with the Intake & Accounts Receivable Specialist before scheduling any future appointments.

_______Health Insurance: Health insurances are used to assist in the payment process; however, you are ultimately responsible for payment. In order to best serve our clients with private insurance, HopeSprings requires that you consent to the following information:

1. HopeSprings is authorized to bill my insurance company on my behalf for services provided.
2. I give permission to HopeSprings to release any and all information required in order to process payment with my insurance provider.
3. HopeSprings is authorized to act on my behalf for obtaining payment, and I authorize the rights to the claims and payments from my insurance to HopeSprings. Should I receive any reimbursement directly for services provided to me by HopeSprings, I will turn over the payment within ten business days.
4. I understand that HopeSprings will assist in submitting billings to my insurance company for payment but that not all mental health services are covered by insurance companies.

Financial and Benefit Information

1. I understand it is my responsibility to communicate any changes to my benefits or financial information, if applicable, to HopeSprings.
2. I understand that at a minimum, HopeSprings will require annual benefit information updates.

Fee Agreement: I understand I am responsible for paying the following amount at the time of each appointment:

$__________________.

By receiving services at HopeSprings, you, the client, acknowledge and agree to all of the terms and conditions set forth in the Client Rights, Informed Consent, Fee Agreement, and Financial Policy form.

HopeSprings Counseling Services

Financial Policy Acknowledgement

I have been informed of the fee agreement and financial policy as described above and understand how they apply to me as a client of HopeSprings Counseling Services.

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Client Name (printed) Date

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Client Signature Date

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Guardian Signature (if applicable) Date

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Witness Signature Date