701 Devonshire Dr. Suites B16-18 • Champaign, Illinois 61820 • 217-531-2360

Fee Agreement and Financial Policy

Client Name: _____ Date: _____

☐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 & Billing Coordinator or the Program Assistant BEFORE signing.

Before scheduling your first appointment, HopeSprings Counseling asks for credit or debit card information that will be kept on file to be used as a form of payment for co-pays, co-insurance, deductibles, late cancellations, missed appointments, and past due account balances. When a fee is applied to your account, the card you selected to be on file will be automatically charged on the date of the fee application.

Fee for Services

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 HopeSprings will submit claim information to your insurance provider, if applicable, to help assist with the cost of treatment.

- If insurance is being used, **ALL** co-pays and deductibles are due and charged at the time of service.
- Co-insurance and service fees will be charged at a later date once an insurance payment has been verified. Payment of these fees will be due at the next day of service after verification.
- If Medicaid is being used, any spenddown fees, if applicable, are due at the time of service.

- Eligibility of benefits is not a guaranteed reflection of benefits paid; therefore, you, as the policy holder, will be personally and fully responsible for any services not covered by insurance.

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

- If you cannot pay for the services at the time of your appointment, you may not be seen.
- Co-insurance and service fees must be paid within 30 days of being applied to your account. A failure to pay this in the 30-day time frame may result in you being discharged from services.
- Accepted forms of payment are cash, check, credit cards (Visa, Mastercard, Discover, and American Express), and debit cards. Checks should be made payable to Cunningham Children's Home.
- If services are paid by check or credit/debit card and there are non-sufficient funds, a $25 fee will be charged in addition to the amount owed for services.
- If you do not have insurance or other benefits 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. Cancellations require at least 24-hour notice by phone. If we are closed or otherwise unavailable, leave a confidential voicemail to cancel. If an appointment is cancelled 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. 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 $175.00)

_____**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 miss your appointment.

_____**Health Insurance**: Health insurances are used to assist in the payment process; however, you are ultimately responsible for payment. Should insurance leave an unexpected

balance on your account, you will be responsible for paying the balance upon notice. Services may be terminated in 30 days if your account is not paid in full.

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 all information required 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 and that failure to do so may result in services being billed directly to me.
2. I understand that at a minimum, HopeSprings will require annual benefit information updates.
3. I understand that I am personally and fully responsible for the cost of any services not covered by my insurance OR payment of services in full under a sliding fee agreement.

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

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. I authorize HopeSprings Counseling Services a Program of Cunningham Children's Home to charge my credit/debit card as needed according to the terms of this Fee Agreement.

_____

Client Name (printed) Date

_____

Client Signature Date

_____

Guardian Signature (if applicable) Date

_____

Witness Signature Date