

FINANCIAL RESPONSIBILITY

Insurance Fees

I am in-network with a select number of insurance companies for my services. Please provide full insurance information and your insurance card upon your initial visit (or before, if possible) so we can determine the benefits for which you are eligible. If you have a change in insurance, please let us know as soon as possible.

Your insurance plan may require me to assess you a copayment, coinsurance or deductible (“cost share”). Mental health appointments are assigned billing codes on claims that vary based on factors such as appointment length and complexity. As a result, your cost share may vary from visit to visit.

Any cost share is due at the time of service. Mindful Therapy Group staff and I will do our best to estimate your cost share in advance of or at the time of your appointment. However, it is possible that your insurance plan, after reviewing the claim, will determine that your cost share is higher than we estimated. In these situations, Mindful Therapy Group will notify you about any balance due with a monthly statement. In the event we overestimate the cost share, the credit will be applied towards your future visits, unless you specify otherwise.

If your insurance plan requires preauthorization for services, it is your responsibility to obtain this authorization prior to our appointment. If you fail to obtain authorization, any and all charges incurred for services rendered by me and not reimbursed to me or Mindful Therapy Group by your health insurance will be your financial responsibility.

Private Pay (Cash Pay) Fees

- \$130 per 53-minute session for individuals.
- \$150 per 53-minute session for couples/families.

Case Management Time Fees

Most clinical issues should be shared in our appointment. If calls and case management become excessive, I may need to charge for case management time. I will always inform you prior to providing this service and prior to billing for it.

- \$100 per hour.

Cancellation Fees

If you are unable to provide more than 48 hours’ notice, you will incur a missed appointment/late cancellation fee as follows:

- \$115 for missing session

This charge is irrespective of the reason for the cancellation/no show. Insurance does NOT cover this fee and will automatically be charged to the credit card listed on file.

While I understand unexpected things sometimes pop up, if there is a pattern noticed of cancelled appointments, I may be unable to continue providing services to you, and I reserve the right to cancel future appointments in order to make room for clients committed to the therapeutic process. I will always communicate about this with you and determine if we're a good fit prior to making changes to your scheduled appointments.

Collections

If you have an unpaid patient balance of \$100 for more than 120 days, the balance may be turned over to a third-party collections agency. You will receive a final courtesy phone call and/or letter to remind you of your balance due. If you believe that there is an error in your billing, please let us know as soon as possible so we can research the issue. Unpaid balances without a payment plan or partial payment initiated after 120 days will initiate a phone collections effort for recovery, and some identifying confidential information will be released in this process. This may negatively impact your credit. It is very important that you update your contact information with us to ensure you are aware of your financial responsibility and receive your statements.

Assignment of Benefits

By signing below, in exchange for, and in connection with, any and all of the services provided to you or your child, as applicable, by me, your provider, you irrevocably assign and transfer to Mindful Therapy Group and me all of the rights, benefits, privileges, protections, claims and any other interests of any kind whatsoever, without limitation, that you or your child, as applicable, had, have or may have in the future pursuant to or in connection with any insurance policy or plan, health benefit plan, health management agreement, risk-bearing agreement, trust, fund or any other source of payment, insurance, indemnity or health or medical coverage of any kind covering you or your child, as applicable. This assignment also includes assignment of your or your child's, as applicable, appeal rights, fiduciary rights, rights to sue, rights to payment, rights to full and fair claims review, rights to penalties or interest, rights to plan documents and plan information, and rights to notices and disclosures from any source that you or your child may have under the health benefit coverage described above.

Patient Name:

Patient Date of Birth:

* If patient is under the age of 18 the patient's parent or legal guardian must sign below unless a minor patient is requesting to be assessed as a mature minor in accordance with state eligibility guidelines

Signed: _____

Name: _____

Relationship to Patient (e.g., self, parent):
