Psychological Testing Insurance Payment

Strong Roots Counseling, Inc
www.strongrootscounseling.com

Strong Roots Counseling, Inc, accepts a small number of insurance plans. Each client's plan and behavioral health coverage varies. It is your responsibility to consult your policy and/or check with your health plan to confirm what specific services are covered under your plan, if you have a deductible, and if Strong Roots Counseling, Inc, is an in-network or out of network provider under the plan. We will submit for the services that we feel are clinically appropriate, but do not know the specifics of your plan and therefore cannot guarantee all services will be covered. All insurance companies require a diagnosis for services; please let us know if you have any questions about what will be submitted to your insurance company. Most insurance companies will only pay for medical necessity diagnoses.

Your signature on this form indicates that the person named below is using their insurance plan for Strong Roots Counseling's services. Your signature below also indicates that you are responsible for all fees and charges for services you, or the person named below, receive while in treatment with Strong Roots Counseling. Your signature serves as permission for Strong Roots Counseling to communicate with your insurance company regarding billing and the disclosure of any relevant clinical information to ensure ongoing sessions as appropriate.

If your insurance changes during the course of treatment, or if Strong Roots Counseling, Inc, changes their relationship with an insurer, it is the responsibility of the appropriate party to inform the other. Please note that the responsible party is required to pay any outstanding fees not covered by insurance within one week of being informed that they are responsible for these payments. A late fee for outstanding payments will be imposed at the rate of $15 per each 15-day period beyond the initial 30-day grace period. Insurance does not cover missed visits, and a fee will be applied to appointments canceled with less than 48 hours notice (see general service agreement). All cancellations must by done by telephone or email. The responsible party is required to pay their co-payment on the date of service.

Please note that it is the responsible party's responsibility to confirm with their health plan whether the services provided to the person named below will be covered by your insurance and to obtain any necessary referrals or authorizations prior to the visit.

Client Name:_____Date of Birth: _____

Signature of client/or responsible party:_____

Name of insurance plan:_____Co-payment amount_____

ID #_____ Plan #_____

Subscriber's Name and Date of Birth _____
(if applicable)

Subscriber's Address and phone number_____

_____

I acknowledge that I have a responsibility for paying at the time of each service. It is my responsibility to notify my provider of any changes in insurance coverage. In the event that I am unable to pay in full, I agree to arrange a financial agreement at the time of each service, and the plan will be agreed upon in writing. If the commitment to the payment plan is not followed through, I understand that Strong Roots Counseling has the right to use a collection agency or other legal measures available to collect all outstanding fees. If a session cannot be billed (as stated above in the cancellation policy) the fee for the missed session will be $100.00 for private pay clients or the contracted rate for your specific insurance plan plus the co-payment or $100, which ever is less. This information is available from your clinician or front desk staff. Insurances will not pay for sessions if someone is more than 15 minutes late for the session.

All clients are required to maintain an active credit card, not FSA card, on file to be charged in the event of a missed appointment, information above, or for a final balance at termination. This credit card will not be used for regular co-payments. This form will be kept in a locked file and is not on any online platform. This permission will conclude once your final payment for services has been completed after you terminate treatment.

Credit card number:_____

CVC Code:_____ Expiration date:_____

Zip code for credit card:_____

Client name: _____ DOB: _____

Signature of client or responsible party: _____

Witness:_____ Date:_____