DOWNTOWN Counseling CENTER

155 S. Hanover Street • Carlisle, PA 17013 • P: 717-386-5971 • F: 717-386-5635

main@dcccarlisle.com • www.dcccarlisle.com

AGREEMENT FOR PAYMENT AND AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

1. By signing below, I agree to contact my insurance carrier to verify and understand my own benefits and coverage. I understand that Downtown Counseling Center, LLC (DCC) can give me an estimate of my insurance costs, but that the final decision is up to the insurance company. If for some reason, my insurance company refuses to pay, I am responsible for payment. _____ (Initial here)

2. I authorize DCC to apply for benefits on my behalf for covered services rendered. I request payment from my insurance to be made directly to DCC. I certify that the information I have reported about my insurance(s) is (are) correct. I also understand that DCC may release necessary information for this or any related claim to my insurance company. I permit a copy of this authorization to be used in place of the original. _____ (Initial here)

3. I understand that I am expected to give 24 hour advance notice if I cancel or change my appointment at DCC. If I do not give 24 hour advance notice and miss my appointment or cancel my appointment less than 24 hours beforehand, I may be charged $60. In addition, if I miss or cancel three consecutive appointments or miss or cancel four appointments in any eight week period the clinic may elect to terminate our relationship with you. My insurance company will not reimburse me for the cost of a missed appointment.____(Initial here)

4. I understand that if I don't disclose all plans under which I am covered, faulty claim filing may occur and I may end up being financially responsible for large sums of money at a later date. _____ (Initial here)

5. I understand that any co-payment, co-insurance, or out-of-pocket payment are my responsibility and is due at the time services are rendered/provided at DCC. _____(Initial here)

6. I verify that I am only covered by the insurance plan or plans that I have listed in my intake documents. I understand that if my insurance plan recoups fees paid to DCC because of unpaid insurance premiums, undisclosed secondary insurance, gaps in coverage, or other reasons that are not the fault of the practice, I am financially responsible for paying DCC for all money recouped. _____ (Initial here)

7. If using insurance, I give permission for DCC to release treatment records to my insurance company if/when my insurance company requests to review my records for audits, data and coding accuracy._____ (Initial here)

8. I understand that reimbursement from my insurance company and my co-payments/co-insurance payments cover the cost of therapy sessions, routine case notes, and brief phone calls. I also understand that other costs are **not** covered by insurance (including, but not limited to telephone consultations 10 minutes or longer, responding to emails, written reports, and preparation for and appearances related to court cases). If such costs are incurred on my behalf I agree to pay: **$170/hour for written reports, extended telephone discussions, and similar activities; $165/hour for activities related to legal claims.** _____ (Initial here)

9. I understand it is my responsibility to PROMPTLY inform DCC of any insurance changes. If DCC is unable to collect from my insurance due to my delay in reporting changes, I will be responsible for making required payments. _____ (Initial here)

10. I understand that collection agencies may be utilized to obtain unpaid debt. The agency will use any or all of my contact information on file to collect the debt._____ (Initial here)

11. I agree to provide DCC with a non-expired, current credit or debit card information to be kept on file. This information will only be used to pay required copays (if needed) or to pay outstanding balances due. _____(Initial here)

12. For separated, divorced, or multiple payers, I agree that only one credit or debit card will be kept on file to pay required copays (if needed) or outstanding balances._____ (Initial here).

_____ _____

Insured/Authorized Person Date

Downtown Counseling Center Date
Provider