DOWNTOWN Counseling CENTER

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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 the final decision is up to the insurance company. If for some reason, my insurance company refuses to pay, I am responsible for payment within 60 days. _____ (Initial)

2. **I understand it is my responsibility to IMMEDIATELY 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 within 60 days. _____ (Initial)

3. 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 directly to my insurance company. I permit a copy of this authorization to be used in place of the original. _____ (Initial)

4. 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 $75. In addition, if I miss or cancel 2 consecutive appointments, or miss or cancel 3 appointments in any 12 week period the clinic may elect to refer you out to another clinic. My insurance company will not reimburse me for the cost of a missed appointment. _____ (Initial)

5. I understand that if I don't disclose all insurance 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 as all insurances have filing time limitations. ____ (Initial)

6. 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. If your copay is not paid, then the next appt may not be scheduled. _____ (Initial)

7. 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)

8. If using insurance, I give permission for DCC to release treatment records directly to my insurance company if/when my insurance company requests to review my records for audits, data and coding accuracy. I understand that I need to sign a release of information to any third party companies completing risk assessments who request my mental health records (PA state law §5100.34). _____ (Initial)

9. I understand that reimbursement from my insurance company and my co-payment/co-insurance payment 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, paperwork, and preparation for and appearances related to court cases). If such costs are incurred on my behalf I agree to pay: **$175/hour for memos, written reports, extended telephone discussions, consulting with other professionals and similar activities; and $175/hour for activities related to legal requests/subpeondas.** _____ (Initial)

10. I agree to not schedule same day psychiatry and outpatient counseling appointments as insurance carriers will not reimburse psychiatry, or if counseling is provided by multiple counselors for the same issue. I further agree to PROMPTLY inform DCC if admitted to inpatient care, begin family based counseling, or if seeing another outpatient counselor. I agree that if DCC is unable to collect from my insurance due to not reporting the above immediately, I will be responsible for making required payments._____ (Initial)

11. I agree to provide DCC with current credit/debit card to keep on my chart. If using a HAS card (can only be used for session fees, it cannot be used for cancel fees, court fees, or paperwork), **a valid credit card must also be kept on file in case your HSA card has insufficient funds or for non-related session fees.** Your card will only be used to pay required copays, late cancelation or no show fees, or to pay outstanding balances due. I understand that I will not be notified for credit card charges ahead of time unless over $400. _____ (Initial)

12. 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. Finicial information is not HIPAA protected. _____ (Initial)

13. For separated, divorced, or multiple payers of children, I agree that only **ONE** credit/debit card will be kept on file to pay required copays (if needed) or outstanding balances. DCC will not alertnate payments between parents. _____ (Initial)

Insured/Authorized Person Date

Downtown Counseling Center Provider Date