CWM COUNSELING
FINANCIAL POLICY

Client First Name: _____**Client Last Name**: _____ **Provider**: _____

Responsible Party : _____ **Relationship to Client**:_____
(if different from client)

Thank you for choosing CWM Counseling as your mental health care provider. We are committed to providing quality care to our patients, including transparent billing practices. Please carefully read and ***initial each statement***, and ***sign the agreement at the bottom***. This is ***required*** prior to beginning treatment. Our practice manager or billing department will be glad to discuss these policies with you.

Payment Method

All applicable insurance co-pays must be paid in full at the time of service. We require clients to provide a credit or debit card to be stored with our HIPAA-compliant, secure electronic payment vendor. For your protection, only the last 4 digits of your card number will display in our system. You will receive an electronic receipt reflecting your payments.

Please be sure to inform us **immediately** of any changes to your credit/debit card information. If the card on file is declined for any reason, future services will be suspended until we receive updated payment information. _____(initial here)

Insurance Billing

Please understand that we must receive current and accurate insurance information in order to confirm active coverage and benefits prior to your first visit. We expect that you will notify our office of any changes to your name, address, insurance coverage, or other information required to bill your services in a timely manner. In addition, you are responsible for understanding your health insurance policy details, including outpatient mental health benefits available, in- or out-of-network status, exclusions on your policy, and authorization or referral requirements. Failure to do so could result in the denial of your claims, and full financial responsibility for all billed charges. **Benefits are subject to all contract limits between you and your insurance and are not a guarantee of payment.* If you disagree with the way a claim is processed by your insurance carrier, you are responsible for disputing this directly with your plan.

For patients without insurance coverage, we offer private pay rates for our services. Your provider can review these specific service costs with you upon request. Payment will be due **at the time of service**. _____(initial here)

Balance Settlement

Please understand that your account balance is the amount that your insurance carrier has determined to be the patient responsibility for your services. When we are notified by your plan regarding the portion that you will owe, the card on file will be charged up to a maximum of $100 as an initial payment on this balance. You will then receive a statement for any additional amount that you owe. Please call our office to make a payment within 30 days of your statement date. We offer a payment plan option that will automatically charge your credit/debit card each month on a day of your choosing. **Please note: We reserve the right to suspend or terminate services for accounts more than 60 days in arrears. Collection activity may be initiated on accounts more than 90 days past due.** _____(initial here)

Missed visits

Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. Missed visits, or those canceled with less than 24 hours advance notice will result in a $40 fee (does not apply to Medicaid clients). Please contact your provider directly if you need to cancel or reschedule. Missed visit fees will be charged to the credit/debit card on file. Please be advised that missing up to two (2) appointments within a 12-month period could result in dismissal from our practice. _____(initial here)

Client/Responsible Party Signature_____ **Date**_____