Carney Counseling and Family Services LLC

Financial Policy

I am concerned about the cost of your healthcare and want to address some issues related to the cost of counseling services in this office. Considerable care has been taken in setting my fees. I want to assure you that the charges accurately reflect the complexity of care rendered and expertise required for you.

MEDICARE: At this time I am not a participating provider nor do I accept Medicare assignment.

HMO AND PPO MEMBERS: If you are a member of an HMO or PPO in which I participate, your deductible and/or coinsurance is required at the time of service. You are responsible to see that I have a current referral on file, if your insurance requires one. If I do not have this referral at the time of your visit, your insurance company may hold you responsible for all charges. You may also be sent back to your Primary Care Physician prior to being treated to obtain a current referral.

If you are not sure if I am a provider for your insurance plan, please look in your insurance directory or call your insurance carrier.

FEE FOR SERVICE: My policy requires the payment of your deductible and/or coinsurance at the time of service.

My agreement is with you, not your insurance company. Although I will submit a claim to your insurance company, you are ultimately responsible for payment for the services you receive. Payment to our office is not contingent or dependent upon your insurance carrier.

BROKEN APPOINTMENTS: You are responsible for payment of a $75.00 "Cancellation Charge" for all broken appointments when no notice has been provided to this office or when notification has been provided less than 24 hours prior to the scheduled appointment. The fee for a second broken appointment is $135.

If you have any questions regarding our financial policy, please feel free to discuss them with any of our billing staff.

INSURANCE ASSIGNMENT: I authorize that my insurance benefits be payable directly to Carney Counseling and Family Services LLC and/or Michael Carney on my behalf. I understand that I am responsible for all deductibles, coinsurance and non-covered charges.

I have read and understood my financial responsibility. Should my account become delinquent and be referred to any third party for collection efforts, I agree to pay all reasonable attorney fees, court costs and a collection expense.

Date:_____ _____

Patient Signature (Responsible Party)

_____

Printed Name

Date:_____ _____

Witness Signature