ViewPoints
Psychotherapy Services LLC

Patient Name

FINANCIAL POLICY

This agreement is intended to provide patients/legal guardians with an understanding of the financial aspects of healthcare services provided at ViewPoints Psychotherapy Services, LLC. Patients/legal guardians should read this agreement carefully before making a decision and proceeding with care.

- ❑ I wish **NOT TO** file insurance:

I am choosing to opt out of filing insurance for my treatment with ViewPoints Psychotherapy Service. I acknowledge that if I change my mind, I **CANNOT** request ViewPoints Psychotherapy Services to back bill my insurance company for services already rendered. I understand that I am eligible for a self-pay discount by choosing this option. I choose to opt out of using my insurance benefits for these services.

- ❑ I wish **TO** file insurance:

I am choosing for ViewPoints Psychotherapy Services to file insurance on my behalf to my insurance company, I have provided a copy of my insurance card and will keep my insurance information up to date all times. I am aware my payer will require information such as a diagnosis, type and cost of service, dates of service, treatment plan, etc. Insurance companies can also require copies of ViewPoints Psychotherapy Services notes in some circumstances. I understand that my insurance company, will only cover treatment they deem to be **MEDICALLY NECESSARY**. I am requesting ViewPoints Psychotherapy Services to file my insurance.

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are **NOT A GUARANTEE OF COVERAGE or PAYMENT**. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that you are personally responsible for payment of any non-covered services, deductibles or co-pays. You may then submit the bill to your insurance carrier for reimbursement.

I understand that I am responsible for payment in full for any services not expected to be paid by a third party. **Payment is due at the time of each visit**. If payment is not made, ViewPoints Psychotherapy Services may stop my services. Past due amounts on accounts can be turned over to a collection agency. I understand and agree that interest, at the maximum legal rate, may be added to any account which is not paid within 30 days after it is initially billed. I agree to pay all costs and legal expenses, including court costs and reasonable attorney's fees, which may be incurred during the collection of any account which is not paid within 30 days after it is initially billed

For out of network insurance coverage **(Tricare)** OR if you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request for more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here at our office.

I understand I must provide a minimum of 24 hours' notice if I need to cancel or change the time of an appointment. Otherwise I will be charged the following applicable fees:

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LATE/CANCELLATION FEES:

Psychotherapy:

- Reschedule/Early Cancel/Cancel: cancels prior to 24 hours No Charge
- Late Cancel/Same Day: cancels after 24-hour window before appt has closed
  - 1st time No Charge
  - 2nd time $25.00
  - 3rd/Final time $50.00
- No Show No Call: does not show to appointment or call and leave a voicemail
  - 1st time $25.00
  - 2nd time $50.00
  - 3rd/Final time $75.00
- No Show Exception: they did not arrive to their appointment, but we heard from them after the fact and there was an exception to be made
  - 1st time No Charge
  - 2nd time No Charge
  - 3rd/Final time $50.00

Med Mgmt./Psych testing fees

- Early Cancel/Cancel: cancels prior to 24 hours No Charge
- Late Cancel/Same Day: cancels after 24-hour window before appt has closed
  - 1st time $75.00
  - 2nd time $75.00
  - 3rd/Final time $150.00
- No Show No Call: does not show to appointment or call and leave a voicemail
  - 1st time $75.00
  - 2nd time $150.00
  - 3rd/Final time $150.00
- No Show Exception: they did not arrive to their appointment, but we heard from them after the fact and there was an exception to be made
  - 1st time $50.00
  - 2nd time $50.00
  - 3rd/Final time $50.00

Medicaid/Medicare Patients:

You understand that ViewPoints Psychotherapy Services, LLC may not charge you for late cancellations, no show fees, or various other fees. However, you understand that the above guidelines still exist. This means after your **third incident** involving patient appointments or care you will be discharged from our practice and need to find alternative treatment. You will be notified by your provider, and a formal discharge letter will be emailed/mailed to you to communicate your services are being terminated.

I understand it is my obligation to cash the checks and issue payment to ViewPoints Psychotherapy Services, LLC immediately.

_____ _____

Signature of Patient Date

In requesting the medical records as the designated agent, in signing below, I attest to the continuing inability of the above patient to make or communicate health care decisions.

_____ _____

Signature of Legal Representative Date

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Self-Pay Agreement

YOUR PATIENT RIGHTS: As a patient who is covered by a medical or behavioral health care policy you have the right to determine the best course of treatment. If you elect to see a provider or a group that is not part of the commercial network you understand that your services may be covered, but result in a higher out of pocket expense for you as a patient. You understand that you have the right to access a provider that is part of your commercial network policy by contacting the insurance carrier directly. You further understand that services provided to you with ViewPoints Psychotherapy Services, LLC may be covered in full should you choose to utilize your commercial network plan. You further understand that by signing this self-pay agreement that you have been informed that even if you are covered by a commercial network policy ViewPoints Psychotherapy Services, LLC will not be submitting any claims to the commercial network on your behalf. You are entitled to know the full cost of services, CPT codes used, and provider information should you wish to submit this information to your commercial network independently.

PRATICE STIPULATIONS:

I understand by signing this self-pay agreement that I am agreeing to pay for all services in full at the time of the appointment, and failure to do so could result in a late fee or penalty charge.

I understand that by signing this self-pay agreement should I wish to change to health care coverage I will notify ViewPoints Psychotherapy Services, LLC in writing of the change and provide all necessary insurance information prior to any services being rendered. This can include determining if services are medically necessary or if a preauthorization or referral are needed for the new plan.

I understand that I was presented with my options to use health insurance or pay independently for care and have opted to pay for care independently at this time due to the following reasons:

- ☐ The patient/legal guardian does not have insurance coverage
- ☐ The provider performing the above therapies is not a participating provider with your commercial health insurance plan. Therefore, some of these services may not be covered by my commercial policy.
- ☐ The scope of therapies rendered by this provider may not be covered by my commercial policy.
- ☐ I am covered by a commercial health policy, but due to costs and the possibility of claim denials I have made a personal decision to pay for care independently. I understand that I can contact the commercial insurance plan at any time to get specific cost and medical necessity guidelines and have not chosen to do that at this time.
- ☐ The appropriate authorization required by my health insurance policy has not been obtained from my primary care physician. It is my personal decision not to obtain the authorization from my primary care physician
- ☐ There was an issue with my commercial health insurance policy at the time of the appointment. This could be due to a technical issue or a lapse in coverage. I understand that should my commercial policy not cover the services rendered today and going forward I will pay the following amounts to compensate for the loss of coverage and denial of the claim.
    - Individual Psychotherapy Session (53-60 minutes) _____
    - Medication Management/Prescriptive Appointment _____

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LIMITATIONS: ViewPoints Psychotherapy Services, LLC will not submit any claims to any insurance network for any patient that has a signed copy of the self-pay agreement on file. ViewPoints Psychotherapy Services, LLC will only provide a statement of services to include CPT codes, provider information, and full cost for services should the patient ask for a copy so they may submit it to their commercial insurance policy.

_____

Patient Name

_____ _____

Signature of Patient Date

In requesting the medical records as the designated agent, in signing below, I attest to the continuing inability of the above patient to make or communicate health care decisions.

_____ _____

Signature of Legal Representative Date