Dr. Sandra Rahe, LIMHP

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Office Financial Policy and Billing Agreement

Name (*print)*:_____Email:_____

Insurance Coverage:

- I agree to contact my **insurance company to <u>verify outpatient mental health benefits</u>.** You pay for your insurance and **it is your responsibility to know the benefits of your policy. _____** (Initial)
- Should a dispute arise on a claim, **it is generally the clients' responsibility to clarify and resolve the dispute with the insurance company. _____** (initial)
- If insurance *is* being filed, any deductible not yet met is **due at the time of service as well as any co-pay. _____** (initial)

Payment:

- If Insurance *is not* being filed, **payment is expected at the time of service. _____** (initial)
- **I agree to provide a 24 hour notice to cancel an appointment or I may be charged a late cancellation fee of $85.00.** If you have Medicaid, the charge is $10.00_____(initial)
- **I agree to pay a no-show fee of $85.00 if I do not attend a scheduled appointment.** If you have Medicaid, the charge is $10.00. **Fees must be paid before your next appointment. _____** (initial)
- **I agree to pay my bill in full within 90 days** and understand my account may be sent to a collection agency if it becomes delinquent. _____ (initial). Credit and debit cards are accepted on website.
- Phone calls are **not** billable to your insurance. Phone calls are **billed for the amount of time spent on the phone, at the pro-rated hourly rate**. (See fee schedule). _____ (initial)
- Fees are subject to change at the discretion of the practice. A fee schedule is available upon request. _____ (initial)
- There is a $30.00 charge for checks that do not clear the bank. _____(initial)

I certify that I have read, understand and agree to the foregoing. The undersigned is the client or is duly authorized by or on behalf of the client to execute the above and accept its terms.

_____ _____

Signature of Client or Responsible Party **Date**

_____ _____

Signature of Witness **Date**