## FINANCIAL POLICY

We strive to exceed expectations and eliminate financial surprises for all our patients. We want to partner with you in keeping your account accurate and up to date. Your patient financial rights and responsibilities are listed below. Please review and sign this document. The original document will be placed in your patient record and a copy given to you for your records by request.

Sherman Counseling in partnership with PACER Clinic, Delta Center, New Directions and Baeten Counseling are state certified outpatient clinics which utilize the following fee schedule:

| Service | Rate | Service | Rate |
|---|---|---|---|
| Therapy | $252-$627/hr. | Missed Appointment/Late Cancellation | $150/hr. |
| Psychiatric Services | $199-$702/hr. | Deposition | $500/hr. |
| Psychological Testing | $317-$627/hr. | Telephone Consultation (15 minutes or more) | $100-$300/hr. |
| PACER Clinic Services | $344-$627/hr. | Letters / Report Writing | $250-$300/hr. |

- I understand that I am responsible for determining whether services are covered under my health insurance plan.
- I will be responsible for the full amount charged if I do not provide Sherman Counseling Clinics with my insurance information. I understand I am responsible for any collection fee(s) associated with my account. I further understand Sherman Counseling Clinics will honor all discounts, fee schedules, and network participation pricing as per signed contract. Other financial arrangements without a signed agreement with Sherman Counseling Clinics will be handled on a case-by-case basis.
- **All payments are due at the time of service**. I understand that if my health insurance does not include coverage for behavioral health benefits, I will be required to pay at the time of service. I understand that have an option to set up a payment plan with Sherman Counseling Clinics for all patients' financial responsibility associated with each account. If I am unable to pay my balance in full, please contact Sherman Counseling Clinics to make arrangements for a payment plan.
- **No Show Fee/Late Cancellation Fee: I**f it is necessary to cancel an appointment, a **24 business-hour notice** is required. There will be a charge **up to $150** for late cancellations and "no shows" applied to my account, except in the case of emergency. For appointments that exceed an hour in duration, a no-show fee will be assessed for each hour scheduled. This charge is not covered by insurance and will be my responsibility. Sherman Counseling Clinics reserves the right to charge a higher fee for consistently missed appointments and also reserves the right to not schedule future appointments.

### Financial Agreement

There are two possible methods of payment for services that have been explained to me. My selection is initialed below:

_____ I have insurance and authorize Sherman Counseling Clinics to submit billing to my insurance company or third-party carrier. I give permission for Sherman Counseling Clinics to submit any additional information necessary to process my insurance claim if requested by my insurance carrier. I understand that $100 is due at the time of service to apply towards my deductible until it has been met.

_____ I do not have insurance, or my insurance does not cover desired services and agree to pay the self-pay rate.

### Financial Obligations

I understand by signing this form insurance benefits may include a deductible, co-insurance and/or co-payment and it is my responsibility to reach out to the insurance company for these benefits. Deductible and co-payment are due at the time of service. I am solely responsible for payment for any services provided, including and not limited to deductibles, co-insurance and/or copayments, denied claims and all charges not covered by insurance. We will assume your deductible has not been met until your insurance company informs Sherman Counseling Clinics otherwise.

I understand that if my balance reaches $500, my services can be suspended until my balance has been paid.

It is my responsibility to provide Sherman Counseling Clinics with all necessary insurance information and to notify the office if there is a change in my insurance status, I understand that Sherman Counseling Clinics will send a monthly statement to my home, and I agree to make a personal payment on the outstanding balance. Any payments more than my insurance payments will be refunded to me by Refresh Mental Health.

| _____ | _____ | _____/_____/_____ |
|---|---|---|
| Client Name (PLEASE PRINT) | Client Signature | Today's Date |
| _____ | _____ | _____/_____/_____ |
| Parent Name (PLEASE PRINT) | Parent Signature | Today's Date |

**Baeten Counseling, Delta Center and New Directions are a division of Sherman Counseling.*
*Revised 3/24/2023*