

Positive Perspectives, Inc.

Financial Policy

Thank you for choosing Positive Perspectives. We look forward to working with you. Therapy requires an investment of resources; this form will help you understand your financial obligations before you begin this process.

- **Our current fees for a 45 to 50 minute session range from \$95 to \$135.** In addition to regular therapy sessions, there may be charges for other professional services you receive, including report writing and record preparation. We charge \$125 per hour for preparation and attendance at any legal proceeding.
- **Payment is required at the time of service.** For your convenience, we accept cash, check, credit card and debit card. We require that you allow us to keep a credit card number on file if your dependent children, adolescents or young adults will be attending sessions without you.
- Many insurance policies offer outpatient mental health or behavioral health coverage. We encourage you to contact your insurance carrier to verify the extent of these benefits and to determine if prior authorization is required for these services.
- If given current, complete and accurate insurance information, we will bill your insurance carrier for services rendered, however *you are ultimately responsible for payment of all charges for professional services and any fees associated with your care.*
- **You will be charged \$50 for a missed appointment** unless you provide at least 24 hours advance notice of cancellation.
- You are responsible for full payment of the account of any dependent child or adolescent you bring for treatment regardless of any custody agreement that may be in place.
- If your account has not been paid for more than 60 days, we have the option to use legal means to secure payment. This may include hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be added to the claim.

Please read and initial each item. If you have questions, please ask for assistance.

_____ I understand that payment is due at the time of service.

_____ I have given the office my current and correct insurance information and I understand that it is my responsibility to notify the office immediately of any changes to this information.

_____ I understand that regardless of my insurance status, I am ultimately responsible for full payment of my account.

_____ I understand that I could be charged \$50 for a missed appointment if I fail to give at least 24 hours advance notice of cancellation.

_____ I understand that if I am bringing a dependent child or adolescent for treatment, I am responsible for full payment of their account regardless of any custody agreement that may be in place.

_____ I understand that I must supply credit card information to keep on file if my dependent child or adolescent will attend appointments without me present.

I attest that the above information is correct to the best of my knowledge. I authorize the release of any information to my insurance carrier necessary to process claims. I authorize payment of all insurance benefits to Positive Perspectives, Inc.

Client Name

Signature of Client or Responsible Party

Date

A copy of this policy/agreement is available upon request.

1/11/2011