CREATING HEALTHY ALTERNATIVES TOGETHER

4475 ROUTE 27 PO. BOX 577 KINGSTON, NJ 08528-0577
OFFICE: (609) 333-1096
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FINANCIAL RESPONSIBILITY FORM

Name(s): _____

Address: _____ City: _____ State: ____ Zip: _____

Bill to: Person responsible for payment of account: _____

Address: _____ City: _____ State: ____ Zip: _____

Federal Truth in Lending Disclosure Statement for Professional Services

Part One Fees for Professional Services

I (we) agree to pay _____ , hereafter referred to as the clinic, a rate of $ ___ per clinical unit (defined as 45–50 minutes for assessment, testing, and individual, family and relationship counseling).

A fee of $ _____ is charged for group counseling. The fee for testing includes scoring and report-writing time.

A fee of $ _____ is charged for missed appointments or cancellations with less than 24 hours' notice.

Part Two Clients with Insurance (Deductible and Co-payment Agreement)

This clinic has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services:

Estimated Insurance Benefits

1) $ _____ Deductible amount (paid by insured party)

2) Co-payment _____ % ($ _____ /clinical unit) for first _____ visits.

3) Co-payment _____ % ($ _____ /clinical unit) up to _____ visits.

4) The policy limit is _____ per year: ___annual _____ calendar

We suggest you confirm these provisions with the insurance company. The Person Responsible for Payment of Account shall make payment for services which are not paid by your insurance policy, all co-payments, and deductibles. We will also attempt to verify these amounts with the insurance company.

Your insurance company may not pay for services that they consider to be non-efficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

Part Three All Clients

Payments, co-payments, and deductible amounts are due at the time of service. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account: _____ Date: ___/___/_____

Release of Information Authorization to Third Party

I (we) authorize _____ to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to _____ .

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: _____ Date: ___/___/_____

Person(s) receiving services: _____ Date: ___/___/_____

Person(s) or guardian(s): _____ Date: ___/___/_____