

FairView Counseling and The Play Therapy Center
Financial Contract and Policy

Client Name _____ Client # _____ Date _____

FOR CLIENTS USING INSURANCE

Insurance Company Name _____ Insurance Phone # _____

Policy/ID # _____ Group # _____

Insurance Subscriber's Name _____

Subscriber's Date of Birth: ____/____/____ Subscriber's Social Security #: _____

Subscriber's Address _____

Subscriber's Phone # _____ Relationship to Client _____

Subscriber's Employer _____

The mission of FairView Counseling is to foster the health and welfare of children by providing affordable counseling and educational services to children, their families, and the community members who directly affect their lives. Client fees are an important source of income to continue our purpose. Failure to uphold your financial responsibility impacts the lives of others.

Payment for services is due at the time of services. We accept cash, check, MasterCard/Visa.

You are responsible to know the coverage for services and levels of payment by your insurance company. You are responsible for any amounts not covered by your plan. If your plan requires a referral, you are responsible for contacting your primary care physician to obtain the appropriate referral for services.

If we are an in-network provider with your insurance plan, co-pay is expected at time of service. We will bill your insurance company for reimbursement. If our charges apply to your deductible or are not covered by your plan, you will be responsible for the unpaid amounts.

If we are not an in-network provider with your insurance plan, you will be charged the full fee for our services, and a receipt will be provided for you to submit to your insurance plan for reimbursement.

There are some services that we may provide for you that may not be covered by your insurance plan, such as court testimony, reports, copies, etc. A list of these services and their fees is posted at the front office.

I understand FairView Counseling's Policy that:

- 1) **24 hours notice is required for cancellation; otherwise a \$40 fee will be charged.** This same fee applies to missed appointments. Insurance companies do not pay for this fee.
- 2) Fees incurred for checks returned from the bank for any reason is the client's responsibility.
- 3) If I have not been active in therapy for a period of (3) months, my case will be terminated. If I wish to return after I have been terminated, I can call and request to be set up for a new intake session.

I have read and understand FairView Counseling's Financial Policy. I understand that I am responsible for all charges, regardless of insurance coverage. I give FairView Counseling permission to release any information that is necessary to support any insurance claims on my account and secure timely payments due to the assignee or myself. If FairView Counseling is an in-network provider for my insurance plan, I hereby assign medical benefits, including those from government sponsored programs and other health plans, to be paid to FairView Counseling. This assignment or a photocopy hereof is acceptable.

Client Name _____

Client or Parent/Guardian Signature _____ Date _____

Copy Given to Client _____