

Christian Counseling Center

A Professional Caring Ministry to Strengthen Families

Financial Policy

(Please Read Before Signing)

MISSION

The Christian Counseling Center is a not for profit organization dedicated to providing quality out patient services for behavioral and mental health based on Christ centered principles. In order to provide this service to all that are in need, we are pleased to inform you of your financial options.

EAP & MANAGED CARE

The Center participates in many Employee Assistance Programs (EAP) and Managed Care Programs. We will gladly provide services according to your plan when proper authorization is granted prior to your visit and we will accept payment according to our negotiated agreement with the Company. You will be responsible only for applicable copayments or deductibles at the time of your visit. However, since authorization is not a guarantee of payment, you will be responsible for services that are not covered by your EAP or Managed Care Plan.

INSURANCE

We are also willing to bill most insurance companies. If we are out of network with your plan it is our policy to ask for payment in full at the time of service until we establish payment from the insurance company. The payment that you make will then apply to your deductible, coinsurance, etc, and any credit that is due on your account will cover your future visits or be refunded to you. Please provide a copy of the front and back of your insurance card on your first visit so that we can begin billing promptly. We do not accept assignment from some companies; therefore, please verify with our office whether we will be able to bill your insurance.

DISCOUNTS

We have an adjusted fee agreement available if you do not have insurance coverage, or find that your plan covers only a small portion of our services. You will simply complete a statement regarding your gross household income and the office staff or therapist will determine your fee. It is our policy that this fee is paid at the time of your appointment and an additional discount of \$15 is applied at that time. Special arrangements for billing may be considered on a case by case basis with administrative approval.

_____ **(Please initial)** Your **APPOINTMENT TIME**: The therapist will make every effort to begin your session on time. A clinical hour ranges from 45 to 60 minutes with the therapist and may include time for documentation and scheduling. Your fee is based on the length of service and number present. Please feel free to ask if you have any questions about your appointment.

_____ **(Please initial)** **NO SHOW/CANCELLATION FEE**: In order to keep our schedules running smoothly and to serve as many people as possible, the policy of the Center is to assess a \$50 no show/ cancellation fee when an appointment is missed or not cancelled 24 hours prior to the scheduled time. In order to avoid this fee, you may simply contact our office within this time frame if you are unable to keep your appointment. It is acceptable to leave a message on the answering machine.

_____ **(Please initial)** **LEGAL SERVICES**: In the event that your therapy involves court-related services, you will be asked to sign a separate agreement and insurance or discounted fees will not apply.

_____ **(Please initial)** **COLLECTION**: We accept payment by cash, check, and select credit cards. Your fee is due at the time of Check-In. There will be a \$20.00 fee for returned check or credit payments. In the regrettable event that you leave our services owing a balance, your account will be transferred after 90 days to Credit Bureau System for collection.

I have been given a copy of the Financial Policy of Christian Counseling Center. My signature on this form indicates that I have read, understood and intend to comply with the conditions of this policy.

Signature _____ Date _____