FINANCIAL POLICY

Thank you for the opportunity to be involved in your health care. We take pride in our efforts to continuously improve all services presented to you. Our goal is to take the hassle out of billing by collecting accurate insurance and payment information at the time of your visit. Below are the financial policies that enable us to manage your financial account here at Hinman Counseling Services.

**Payment Terms**

Payment for all charges is expected at the time of service. Acceptable forms of payment include your insurance, Visa, MasterCard, Discover, Checks and Cash. All returned checks will result in a $30.00 service fee charged to your account.

**Billing Process**

We bill participating insurance companies as a courtesy to you. You are responsible for paying deductibles and copays at the time of service according to your insurance policy. All charges incurred at Hinman Counseling Services are your responsibility. If no payment is received from your insurance company within 60 days, you will be expected to pay the balance in full. Patients with an outstanding balance over 60 days old must make arrangements for payment prior to scheduling any additional appointments. If no payment is received by you, collection action may be taken against your account, and resulting collection fees no greater than 30% will be added to your balance.

**Missed Appointments**

If you are unable to be present for your scheduled appointment, please call to cancel at least an hour before your appointment time. Any missed appointments will be logged within your chart, and could result in a $30 fee added to your account. Please fill out the following sheet with the valid credit card you wish for us to use to pay for the missed session. This information is required to receive services at Hinman Counseling Services.

**Minors**

All patients under the age of 18 must be accompanied by a parent or legal guardian at the first session. Whoever brings a minor patient to the office is considered responsible for their charges for the day, and must make all necessary arrangements for payment of services provided.

**PATIENT ACKNOWLEDGEMENT**

*I verify that I have read and understand the Notice of Privacy Practices and Financial Policy of Hinman Counseling Services, and I understand that I may request a copy of these policies at any time. I agree to accept full responsibility for all services rendered, as well as all fees represented within my financial account. I hereby give Hinman Counseling Services permission to release all necessary information to my insurance company for billing purposes.*

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 Patient Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Patient or Representative Relationship to Representative

 (*circle one*)

Credit Card type: Master / Visa / Discover

Credit Card#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Security Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*on back of card*)

Name on the front of card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I authorize Hinman Counseling Services to charge a $30 late cancellation fee for appointments I fail to cancel within 24 hours prior to appointment date and time. No other use of this card will be authorized without my prior approval.***