**TERMS OF BILLING/CONSENT**

\*PATIENT COPY\*

* **Clients are responsible for knowing their insurance benefits and plan requirements. Therefore, if your insurance company does not pay you are responsible for all charges incurred.**
* The fee for an assessment for an episode of care is $150\*. Ongoing therapy is $100\* per session (45 minutes). Group therapy cost depends on the group and time commitment. (20% provider discount when choosing fee for service and paid the day of appointment.)
* **There is a $50 charge for non-emergency no-shows and/or cancellations made less than 24 hours in advance (unless there are rules that prohibit us from doing this). These cannot be submitted to your insurance company. This must be paid prior to your next scheduled session. If there are repeated cancellations or no-shows the therapist may choose to discontinue care and provide referrals. Therapists can choose to not charge based on reason for the cancellation.**
* If you become involved in legal proceedings that require your therapist’s participation, you will be expected to pay for all of his/her professional time, including transportation costs, even if he/she is called to testify by another party (fee for preparation and attendance at any legal proceeding is $200 per hour). A retainer sum of $500 shall be placed in the Northwest Account. Services performed by this office will be billed in accordance with this agreement. Because each case is unique, we cannot estimate the amount of time we spend on your case. Therefore, we cannot predict the complete cost you will be required to pay.
* If you share legal custody of your minor, attending therapy, both parents have to consent and be informed the child is attending therapy. In addition, health information can be shared to both parents, unless there is written legal documentation that states one parent does not share legal custody. Payment is the responsibility of the legal guardians based on their legal documentation and this office will bill the guarantor, as stated by the parent. It is then the parents responsibilities to coordinate payment to this office.
* I will pay my co-payment of each visit and/or the total amount due.
* I will notify you immediately of any change in insurance company. Without such notification, any refusal on the part of my insurance carrier to pay for services because of needed preauthorization will be my responsibility.
* I consent to release of protected health information to **my insurance company or EAP group** for the processing of claims, care coordination and treatment determination needed to respond to the inquiry. I understand Northwest Counseling will give only the **minimal necessary information needed to respond to the inquiry.**
* If I am covered or believe I am covered by Medical Assistance (MA), I authorize this office to contact the county or counties as it relates to my MA number and coverage. I also authorize release of protected health information to MA for billing and prior authorization purposes.
* If my account becomes past due (60 days) and I have not arranged for or made regular payments, I understand Northwest Counseling may turn my account over to a collection agency and/or small claims court to obtain payment. My failure to make payments or arrange payments to settle my account is **tacit authorization** for Northwest Counseling to release the minimal protected health information necessary to the collection agency and/or small claims court.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Northwest Counseling. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. In signing this,

I am consenting to:

1) terms of billing

2) release of health information as needed for collection purposes

3) medical benefit assignment

4) Understanding of HIPPA, limits of confidentiality and Client Bill of Rights

Important policies are viewable on our website. Please read our **Notice of Privacy Practices, and Bill Of Rights of Clients**. Would you like a hard copy? YES\_\_\_\_ NO\_\_\_\_

I have received the limit of confidentialities. Yes\_\_\_\_

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Name Date