COVERAGE CHANGES

- If your insurance changes, please notify us before your next appointment so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

NONPAYMENT

- If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you/your immediate family members may be discharged from the practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative care. During that 30-day period, the service provider will only be able to treat you on an emergency basis

LATE CANCELLATIONS OR NO-SHOW APPOINTMENTS

- If you are unable to attend your scheduled appointment, notification to The Clinic for Mental Health and Wellness to cancel the appointment, needs to be done at least 24 hours prior to the appointment time. You can call the office, decline via text or email through the appointment reminder, or send notification through the patient portal to cancel the appointment. We reserve the right to charge at least $25, up to the full amount, for appointments not canceled 24-hours prior to the scheduled appointment time. This fee will be implemented after 3 late cancellations. These charges will be your responsibility and billed directly to you as insurance won't cover this charge. Please help us to serve you better by keeping your regularaly scheduled appointment.
- If the appointment is missed without prior notification (no show), The Clinic for Mental Health and Wellness reserves the right to assess a missed session fee of at least $50, up to the full amount. If there are 5 now show appointments within the course of a year The Clinic for Mental Health and Wellness reserves the right to discharge you from the practice for a period of at least 1 year.
- Please be advised that being more than 15 minutes late may require you to reschedule

CHARGES

- Fees are based on the length and type of evaluation or treatment, which are determined by the nature of the service.
- IEP, MDT, Treatment Team meetings, court appearances, and court testimony are billed at separate rates. Please speak with your provider for more information

PHONE AND EMAIL

- We will return phone message at our earliest convenience, usually within one business day.
- In the case of an emergency, please call 911 or 988.
- We do not use email as primary communication.
- The patient portal is considered HIPPA compliant so direct communication about billing / payment can be communicated through there. As well as, payments can be made through the patient portal.
- Please contact The Clinic for Mental Health and Wellness via phone for questions / concerns.

INDEPENDENT PRACTICE

- Please note that each provider within The Clinic for Mental Health and Wellness is an independent practitioner. All practitioners work under policies and protocols consistent with licensing standards and ethical guidelines.
- Please make all payments directly to the practitioner who provided you the service.

The Clinic for Mental Health and Wellness is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy

CLIENT'S PRINTED NAME

CLIENT'S SIGNATURE / AUTHORIZED PERSON'S SIGNATURE Date

The Clinic for Mental Health and Wellness
CONFIRMATION OF DOCUMENTS

I acknowledge that I have had the opportunity to read and ask questions about the Client Handbook.

Please initial next to each item:

_____ Informed Consent and Disclosure

_____ Privacy Practice Notice (HIPAA Privacy Rule of Patient Authorization Agreement, Privacy Rule of Patient Consent Agreement)

_____ Health and Safety Procedures

_____ Your Rights and Our Responsibilities

_____ Grievance Policy

If you would like a copy of any of these documents, please speak with the front staff or your service provider.

By signing below, I acknowledge that I have reviewed the following documents and accept their terms:

_____

CLIENT'S PRINTED NAME or AUTHORIZED PERSON'S PRINTED NAME (If a minor)

_____

CLIENT'S SIGNATURE / AUTHORIZED PERSON'S SIGNATURE (If a minor) Date

_____

AUTHORIZED STAFF'S WRITTEN NAME

_____

AUTHORIZED STAFF'S SIGNATURE Date

For Office Use Only:

Please check ONE:

☐ Adult IOP

☐ Adolescent IOP

☐ Outpatient Adult

☐ Outpatient Child / Adolescent

☐ Title 25