FINANCIAL POLICY & INFORMED CONSENT

The therapists and staff at Affiliated Family Counselors are committed to providing the best possible care. It is important to our professional relationship that you understand our fee and payment policies. Please review the following information carefully and sign as indicated. If you have any questions about our fees, our policies, or your responsibilities, please let us know.

All patients must complete the **Patient Information Form** prior to seeing our counselors. You are responsible for notifying our office of any patient information changes (i.e. address, name change, insurance change, etc.) Any charges incurred due to the failure to report changes of information are the full responsibility of the patient or responsible party. There is an Appointment Hold Fee of $50.00 to $100.00 depending on the type of appointment scheduled, this is used to hold the appointment and will be put toward the co-pay or deductible if the client shows up for the appointment If you fail to show up for the first appointment or do not call 24 hours in advance to cancel the $50.00 will be kept by the agency. FMLA/Social Security paperwork is $35.00. Records is $25.00 plus 0.59 per page for retrieval and copies.

Affiliated Family Counselors will file patient insurance claims upon receipt of complete insurance information including a photocopy of the insured's card. We will bill secondary insurance, but if they do not pay then you will be responsible. We can bill a third insurance party if the correct information is provided. AFC will not become involved in disputes between patients and their insurance providers; however, we will supply factual information as necessary. You are responsible for the timely payment of your account. This includes, but is not limited to deductibles, co-payments, non-covered charges, and "usual and customary" charges. You will be notified by your insurance company of all payments made to AFC on your behalf and any non-covered charges or remaining balance on your claim. Please call our billing office to make payment arrangements upon receipt of a patient account statement indicating an unpaid account balance.

AFC will do our best to assist in obtaining reimbursement for flexible spending accounts, however AFC will not become involved in account disputes. At your request, you will receive a receipt for services. In addition, AFC will provide you with a copy of applied account payments, once monthly, per patient request. Any additional reporting will be subject to administrative fees.

If a referral is required for your insurance, it is your responsibility to obtain the referral prior to any appointments. Failure to obtain a referral may result in reduction of benefits and any non-covered charges will become the responsibility of the patient. Copayments and/or coinsurance are due in full **PRIOR** to being seen by a therapist.

I understand if I have an unpaid balance to Affiliated Family Counselors (AFC) and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for, Affiliated Family Counselors or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that AFC and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

****I UNDERSTAND I MAY BE CHARGED FOR ANY MISSED APPOINTMENTS OR CANCELLATIONS WITHOUT 24-HOUR NOTICE.**

Payment in full is due at the time of service unless prior arrangements have been made through the business office. We accept cash, checks, Visa & MasterCard. Any overdue balances may be considered for further collection action.

The charge for a returned check is $35.00, payable by cash or money order. This will be applied to your account in addition to the insufficient fund amount. You may be placed on a "Cash Only" basis following any returned check.

If the patient is a minor, the parent/guardian is responsible for full payment and will receive all billing statements.

Clients under the age of 18, who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Because privacy is often crucial to successful progress, particularly with teenagers, we may request that the parents give up access to their child's records. If they agree, we will provide the parents with a summary of the child's treatment when it is completed unless the child is in danger or is a danger to someone else. In this case, we will notify the parents of the situation immediately.

A signed release to treat may be required for unaccompanied minors.

If you become involved in legal proceedings that require a therapist's participation, you will be expected to pay for all professional time, including preparation and transportation costs, even if the therapist is called to testify by another party. Due to the difficulty of legal involvement, AFC therapists have a separate rate for preparation for and attendance at any legal proceeding.

In the event you would like AFC to share your patient record with another provider or physician, a Release of Records Consent must be completed. No patient information will be shared without a signed release on file.

AUTHORIZATIONS:

Consent to treatment: I hear by grant consent for treatment or services to be provided by an Affiliated Family Counselors clinician. I also certify that no guarantee/assurance has been made as to the results which may be obtained.

Consent to treatment for Minors & Dependents: I hear by grant consent for treatment or services to be provided to my child or dependent by an Affiliated Family Counselors clinician. I also certify that no guarantee/assurance has been made as to the results which may be obtained.

Financial Agreement: I have read and fully understand Affiliated Family Counselors' financial policies and understand that I am responsible for all changes and fees regardless of insurance coverage.

Insurance payment of benefits: I authorize payment of benefits to be made on my behalf directly to Affiliated Family Counselors for services rendered.

Appointment Cancellations: I understand that I may be charged for any missed appointments or cancellations without 24 hour notice and fully understand that charges incurred are the responsibility of the patient or responsible party.

Informed Consent: I have read and fully understand AFC's policies and procedures and consent to the terms outlined.

Release of medical information: I consent to the release of my medical records by the undersigned AFC clinician for the purpose of review or audits or for necessary insurance purposes to authorized representatives of my insurance provider.

Protected Health information: I consent to the use and disclosure of protected health information by Affiliated Family Counselor providers, staff and business associates for treatment and payment and fully understand the terms outlined in Affiliated Family Counselors' Patient Privacy Practices. I acknowledge that I have been given the right to review AFC's Notice of Privacy Practices and have any questions answered prior to signing this consent.

Policy Changes: Affiliated Family Counselors reserves the right to change its policies at any time based on the needs of AFC and in accordance with state and federal law.

Patient/Responsible Party:

_____	_____	
PRINT	Patient Name	Date of Birth
_____	_____	
SIGN	DATE	