AMERICAN BEHAVIORAL CLINICS FINANCIAL POLICY

Agreement Regarding Insurance, Benefits and Payment

Patient Name: _____ **Date:** _____

We believe that part of good healthcare practice is to establish and communicate a financial policy to our patients. For that reason, we have set forth our financial policy below.

To ensure you understand and agree to our Financial Policy Please Initial & Sign as indicated below:

Payment: Payment is expected at the time of your visit. We accept cash, check, or credit card. Payment includes any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance or do not provide us with your updated insurance benefits, payment will be due at the time of service

I understand I am responsible for paying all fees in full at the time of services, and American Behavioral Clinics (ABC) has the right to reschedule, cancel, and/or terminate services due to therapeutic or payment non-compliance. ***Initial:*** _____

Insurance: As a courtesy, ABC uses its best efforts to verify your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, and sometimes the claim may process differently from the benefits quoted. While we will do our best to assist you in verifying insurance coverage, it is ultimately your responsibility to understand your benefits.

I understand that I am responsible for understanding my benefits and whether ABC services are covered by my insurance plan. It is my responsibility to provide ABC with updated insurance information so that ABC may file my claim. If my insurance company does not pay the practice within a reasonable period of time, the balance will be transferred to me, and I will be billed. I am ultimately responsible for payment of services regardless of insurance coverage. ***Initial:*** _____

Missed Appointments: *I understand that unless cancelled at least 24 hours in advance,* I will be *charged a fee of up to $85.00 for missed or late cancelled appointments. Insurance plans will not cover these charges, and I am therefore responsible for this payment. Missed appointments may result in being discharged from the practice.* ***Initial:*** _____

Accounting Principles: *I understand payments and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.* ***Initial:*** _____

Returned Checks: *I understand that a fee will be charged to my account for returned or stopped payments. I understand that if I have not made payment at the time of my next appointment, my appointment may need to be rescheduled.* ***Initial:*** _____

Overdue Balances: I understand that payment on my account is due immediately after a statement is issued. After three statements, failure to make payment in full or make payment arrangements with our office will result in my account being subject to collections and a collection fee will be added to my bill. **Initial:** _____

I have read and understand the ABC financial policy and I agree to be bound by all terms above. I also understand and agree that such terms may be amended by ABC from time to time.

Signature of Patient or Person Responsible Party: _____**Date:** _____