art therapy of mn

ACKNOWLEDGEMENT OF BILLING TO 3RD PARTY PAYER AND FEE CONTRACT

I _____, acknowledges _____will release information
Client or Parent/Legal Guardian Therapist Name
regarding assessment, diagnosis, and treatment planning to Medicaid services or other 3rd party payer (i.e. insurance provider/waiver entity) only for the purpose of billing and payment collection.

_____ _____
Client or Parent/Legal Guardian Signature Date

I agree to pay any out-of-pocket, co-pays or ate cancellation fees through my credit card, which will be kept securely on file.

I understand that I am ultimately responsible to verify my active coverage with Medicaid or other 3rd party payers (insurance provider/waiver entity) and that services are covered under this provider in full. I understand that if this provider is not covered or if insurance has lapsed, I am responsible to pay full-billed amounts. If insurance only covers services at "out of network" coverage, I am aware that I will need to pay the difference in the amount covered and the amount billed. I understand that I am responsible for understanding the guidelines for my specific coverage. I will become aware of session amount limits and keep track of them as to not exceed limits that are reimbursed by MA or other insurance provider/waiver entity. If I go over these session limitations, I am responsible for covering the fees for all sessions un-paid.

I understand that I am expected to attend my appointment as scheduled, or give 24-hour notification if an appointment will be missed. I understand that there will be a late-cancel fee charged that will need to be paid out-of-pocket if I cancel with less than 24 hours notice. I understand that my therapist will communicate clearly what their individual late cancellation policy and fee is to me. I understand that insurance does not cover late cancel or no-show fees.

I understand that I am expected to be on time to my appointment and if I am more than 15 minutes late without given notice, may be asked to reschedule my session and be charged the late cancellation/no show fee. If I am more than 15 minutes late and the therapist is still available, I will be allowed to meet only for the remaining time in my session and will be charged the regular session fee.

I understand that after sufficient notice and attempts to work on a payment plan, any unpaid balances may be sent to a collections agency.

_____ _____
Client or Parent/Legal Guardian Signature Date

_____ _____
Therapist Signature Date