Wham Counseling, LLC

Payment Policy and Agreement

Dear Patient,

We are committed to providing you with the best possible care, if you have medical insurance we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. Payment or co-payment for services is due at the time services are rendered. We will be happy to process your insurance claim for reimbursement. The attached Assignment of Benefits is required for us to correctly submit your insurance claim.

Returned checks will be subject to additional collection fees.

We will gladly discuss your proposed treatment and answer any questions related to your insurance.

It is important for you to remember:

1. Your insurance is a contract between you, your employer (if applicable) and your insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies and these are covered up to the maximum allowance by each carrier. This applies to only to companies who pay a percentage (such as 50% TO 80%) OF "UCR." "UCR" is defined as usual, customary and reasonable fees for this region. Thus most companies consider our fees usual, customary and reasonable.

3. Not all services are a covered benefit in all insurance contracts. Some insurance companies arbitrarily select certain services they will not cover. We must emphasize that as a mental health provider our relationship is with you not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us as promptly for assistance in the management of your account.

4. As a courtesy to our patients, we will attempt to determine what mental health services are covered by your insurance company prior to the start of treatment. Please note that this information should be considered an estimate only and not an exact determination. Again, our relationship as a mental health provider is with you and not your insurance company. You will be responsible for all charges from the date services are provided.

5. You and your insurance company will receive a statement for all services provided. Patient and guarantor jointly and separately agree to pay the clinician the balance of the patient's account within 30 days from the date shown on the face of the statement. In the event of failure to make payment in full within 120 days from the date shown on the face of the statement we shall have the right to take necessary legal action to collect the same, together with reasonable attorney's fees.

6. Please do note we cannot extend excessive credit on the outstanding amount owed. If the amount owed exceeds $500.00 no further services may be provided until payments are made.

7. It is your responsibility to inform us when your insurance coverage changes and to provide us with the appropriate plan information.

8. **Appointments should be cancelled 24 hours before the scheduled appointment time or the patient (not the insurance company) will be charged a fee for the appointment. The fee will be $100 for a missed appointment.**

9. Due to the volume of patient calls, patients may be charged for telephone consultation.

10. I authorize Wham Counseling and any of its' agents to contact me by telephone, at any of the numbers provided including any wireless number for me and/or my spouse, which could result in charges to me/us. I authorize that my spouse or I may also be contacted by sending text messages and/or emails, using any email address provided. Furthermore, I also authorize methods of contact which may include using pre-recorded, artificial messages, or automatic dialing devices. This express consent applies to all past and current accounts in this office. I/we understand that if any unpaid balance is assigned to a third party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of this account, a collection fee equal to 33 1/3% of the unpaid balance will be added to my account. I/we agree to pay that fee. I/we further agree to pay reasonable attorney fees and court costs if a judgment is granted against me/us.

If you have questions about the above information or any uncertainty regarding your insurance coverage, please do not hesitate to ask us. We are here to help you.

Guarantor: ______________________ Date ______________________