



Fees and Payment Policies – Private Insurance

- Advance payments / account credits will be refunded if they do not apply towards any balance owing. _____
- A **\$150.00 fee** will be charged for any cancelled and missed appointments **unless 24 hour notice is given.** _____
- ITSNW accepts credit cards, debit cards, check, and cash. Any default on payment (credit card refusal, NSF check, etc.) will result in an additional fee and collection action. Future appointments may not be scheduled if there is an outstanding balance on your (or your child's) account. _____

Insurance Billing

- The intake fee is \$220.00. Both individual sessions and family sessions are \$150.00 per 50 minutes. Additional charges may apply (see page 2 of the disclosure information form). Your insurance will be billed for each session. _____
- Group therapy is \$40 per hour. The first hour is billed to insurance. The fee for the second hour is \$20.00 out-of-pocket. _____
- **Please pay your co-pay as you check in.** If payment is not provided to the receptionist, the card on file will be charged for the amount of the co-pay. _____
- Coinsurance payments, if any, are due after the claim has been processed by the insurance company. Please note, coinsurance is different than a co-payment. _____
- **You are responsible for notifying us of any changes that affect billing, including your insurance coverage, subscriber name, or address. If you lose insurance coverage at any point you will be responsible to pay the fee for the non-covered sessions.** _____
- I attest that I am not covered under Medicaid/Apple Health/ProviderOne. _____

Client Statements

- **ITSNW does not accommodate clients carrying a balance on any accounts after insurance has paid its portion.** Therefore, clients must provide credit card information and keep payment information up to date. This means that after insurance has paid its portion, ITSNW will send you a statement. The balance is due upon receipt of the statement. Balances not paid within 30 days of invoice date will incur a \$10.00 late payment fee. Any balance over 30 days past due (including the late fee) will be charged to the card on file. (Please initial option 1 OR option 2 below)
 - **Option 1:** _____ Charge the full amount to my credit card after insurance has paid its portion.
 - **Option 2:** _____ Please provide a statement so I can pay my balance in full. I understand that any balance that has not been paid within 30 days of invoice date will incur a late payment fee.**

**** Please note that a credit card is required to be kept on file with ITSNW.
The card will be automatically charged only for co-pay payments and past due balances.
Please provide the credit card to be kept on file to the receptionist. ****

Email for Reminders and Invoices: _____

Client Name: _____

Client Signature: _____ **Date:** _____

Guardian Name: _____
(if client is under 18 years old)

Guardian Signature: _____ **Date:** _____
(if client is under 18 years old)