Integrated Therapy Services

Fees and Payment Policies – Commercial Insurance

- 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. _____
- Accounts over 30 days past due may result in collection action, up to your account being sent to a collection agency. _____
- A **$150.00 fee** will be charged for any cancelled and missed appointments **unless 24 hour notice is given.** _____

Insurance Billing

- The intake fee is $250.00. Both individual sessions and family sessions are $175.00 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. _____
- I acknowledge that I have read and understood the Assignment of Benefits on the back of this page, which allows my insurance to pay ITSNW directly for services. _____
- **Your co-pay is due at time of service.** If payment is not provided to the receptionist, the card on file will be charged for the amount of the co-pay. This applies to in-person and telehealth sessions. _____
- Coinsurance and deductible payments, if any, are due after the claim has been processed by the insurance company. Please note, coinsurance and deductible are 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/Medicare. _____

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. Statements are sent at the beginning of each month and are due on the last day of the month. Any statement balance not paid by the last day of the month will be charged to the payment card on file. In the instance that the payment card on file declines, a $10.00 late payment fee will be added to the account. Future sessions cannot be scheduled until the balance has been resolved. _____
- I consent to receiving my statement electronically. _____

Email for Invoices: _____

Emailed invoices may include patient information (name, DOB, etc.). By providing an email address, you are consenting to receiving invoices and statements via email.

By signing below, I am indicating that I have read and understood the above terms and conditions.

Client Name: _____

Client Signature: _____ Date: _____

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

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ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your mental health benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY BENEFITS DIRECTLY TO INTEGRATED THERAPY SERVICES NW, PLLC.

_____ _____

Signature of Responsible Party Date

_____

Name of Patient