##### Financial Policies Agreement

Revised

**This agreement supersedes all previous related agreements.**

**Insurance**

If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our payment policy. You will be asked to update your personal and insurance information periodically, including providing our office with copies of your insurance card and driver's license. We are required by law to obtain your signature for permission to release information to your insurance carrier. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements. We will gladly submit fees for your covered medical services to your insurance company, if your provider is considered in network.

However, we expect payment of all services rendered within 60 days. It may become necessary for

**you to pay your account in full if your insurance company fails to pay for services within 60 days.** It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements. We will, however, assist you to ensure that all plan requirements are met. X\_\_\_\_(Please initial)

I understand that SBHS will file and attempt to collect from my insurance company. I further understand that if the claim is not paid within 60 days that I will be billed for the remaining balance. I agree to waive any insurance company policy rights that would prevent me from being responsible for these unpaid charges. X\_\_\_\_\_ (Please initial)

If your insurance coverage or your insurance carrier changes and you do not notify SBHS within 30 days of that change, SBHS reserves the right to NOT issue a refund. I agree to waive any insurance company policy rights that require refund of the aforementioned monies. X\_\_\_\_\_(Please initial)

**Payment for Services**

**Payment for services, including co-payment and deductible amounts, is due at the time services are rendered unless payment arrangements have been approved** in **advance by our staff.** We accept cash, checks, MasterCard and Visa. Our failure to collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to pay these amounts to your employer and/or insurance company representative. X\_\_\_\_\_\_(Please initial)

Failure to pay your co-pay at the time of service will result in a charge of $20.00 to help cover the additional administrative costs. You will be asked to sign a promissory note for the co-pay amount plus the service fee.

X\_\_\_\_\_(Please initial}

**Returned checks will result in a $50.00 fee that will be posted to your account.** Returned checks, balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees. We may investigate your credit record to determine your ability to pay your debt. SBHS has a "One Bad Check" Policy. If your account has one returned check then you will not be allowed to write checks for future services.

**SBHS is a partner in the Loudoun County Commonwealth Attorney's check enforcement program and as such we are required to note a current** / **valid** ID **on each check.** X\_\_\_\_\_(Please initial)

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Continued**:

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.

**Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.** X **\_\_\_\_**(please initial)

1. I accept financial responsibility for all clinical and administrative services provided by Sterling Behavioral Health Services, LTD.
2. I authorize the release of any medical, mental health, or other information necessary to process a claim with my insurance carrier.
3. I authorize payment to Sterling Behavioral Health Services, LTD for all services rendered. I authorize the use of this signature on all my insurance submissions whether manual or electronic.
4. In many cases, there is a need for us to exchange information with other parties, such as other treating physicians. If you do NOT wish to give us permission or have any doubts about granting this permission at this point to exchange information with other physicians, please cross out this paragraph. If you cross out this paragraph, we **will** ask you to sign separate release of information forms when and where appropriate.
5. Ancillary services, which are all services not part of an initial assessment (including exchange of information, as in #4 above) performed by the physician, psychologist, social worker, nurse practitioner, or therapist at Sterling Behavioral Health Services (SBHS) that are provided during non-appointment times will be billed at the provider-specific hourly rate as noted below. Ancillary services are all services provided outside of scheduled appointment times and are not covered by insurance. Examples of ancillary services include but are not limited to: All patient related phone calls including phone consultations with patient or family members, physicians, therapists, psychologists, school officials (administrators, teachers, counselors, etc.), attorney, etc., crisis counseling on the phone, time associated with preparing for non-appointment medication refills, completion of any forms during non-appointment times, etc. Legal and court related matters are billed at a higher rate and require a prior contract and retainer.

Psychiatrists bill at a rate of $450 per hour, at $37.50 per five-minute increments. Psychologists bill at a rate of $350 per hour at $87.50 per 15-minute increments. Master's level providers (social workers, therapists, nurse clinical specialists, and nurse practitioners) bill at a rate of $250.00 per hour in $62.50 per 15-minute increments. Legal and Out of Office services are billed at the above rates per hour, for a minimum of 4 hours - including travel and wait time.

1. If my account goes to a third party for collections, I am responsible for all fees incurred.
2. I understand that if I have a balance on my account that it needs to be paid before my appointment and that failure to pay the debt may result in me not being seen and a missed appointment fee being added to my account. If you are unsure of your balance, you may call SBHS.

By signing this form, I acknowledge that I have read, fully understand and agree to abide by the policies and fees in this agreement.

Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card Authorization Form**

Be advised all credit card information must be called into the office and this form must be completed and signed before any charges are made to your card. For security reasons NO credit card numbers will be written on this form.

Please be aware you may cancel or update this authorization form at any time by notifying us via phone (703) 858-9841 or by email - frontdesk@sbhsva.com.

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| --- |
| **Credit Card Information** |
| Card Type: \_\_\_\_\_Debit \_\_\_Credit \_\_\_FSA \_\_\_HSA |
| The following person(s) have my consent to put the given credit card on file under their account: |
| Name: DOB: |
| Name: DOB: |
| Name: DOB: |

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the card holder of this account authorize Sterling Behavioral Health Services to charge this credit card on file for my services at SBHS and any other persons under my guardianship listed above. I understand insurance rates for services are based on my insurance plan; for all deductibles that have been met, I must notify the billing department to ensure I'm charged the correct rate. If I'm self-pay, I understand rates are based on the billing code(s) associated with my services and are subject to change annually.

I also understand my card will be charged the amount due on the date of service and may also include late cancellation fees and missed appointment fees; rates for such are dependent on my provider.

I am aware an attempt will be made by SBHS staff to notify me of any balances exceeding $250 before my card is charged. In addition, if my card is canceled. expired, etc.; it is my responsibility to notify the office of said change to be updated immediately. If several attempts are made with no successful of reaching me. I understand my card will be charged the outstanding balance. I'm aware that flex-spending cards such as HSA or FSA cannot be used for late cancellations fees or missed appointment fees and I will be responsible for paying those charges. I will provide the office with an alternate form of payment such as a debit or credit card if necessary.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Parent/Guardian Signature Date