A New Day In Pediatrics

Child and Adolescent Health Specialists, PC
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Counseling Payment Agreement

Name of Patient _____

- Fee Structure-
  - $150 per one on one session (individual, parents only or family)
  - $30 per Telephone consultation/Collateral Contact/Case management (over 10 minutes) (not covered by insurance). Care management services may be covered by insurance, copay/deductible may apply
  - Payment is expected at time of appointment/service by cash, check or credit card
  - If an economic hardship develops, a reduced fee or other accommodations may be available. Please present 1040 tax form. Federal guidelines will be followed.
  - Other non- covered services are payable on date of service
- Insurances accepted to which we will submit claims- Blue Cross and Blue Shield (See back of insurance card for Mental Health benefits), United Behavioral Health (for Harvard Pilgrim/ United Healthcare), Tufts, Cigna, Tricare. If you have out of network benefits, payment is due at the time of appointment and we will provide you with a receipt for you to submit to your insurance for reimbursement.
  - Client is responsible for co-payment at the time of the appointment.
  - By law, our Practice cannot waive or reduce insurance fees or co-payments.
- Late Cancellation/Broken appointment policy-
  - 48 hours' notice during business hours, (Friday for Monday appointments), is required to cancel or reschedule an appointment.
  - Late Cancellations/No show will be charged to your credit card below if less than 48 hours' notice is given.
- Late Arrival Policy-
  - For each 15 minutes that a patient is late, you will be charged $50, due on that date of service. If you are over 30 minutes late, you will be charged $150 and the appointment will be rescheduled.
- Balances due- Balances including late/no show fees will be charged to your credit card on file.
  - Outstanding balances must be paid prior to the next appointment.
  - Appointments cannot be scheduled if balances have not been addressed.

Agreement: I understand that I am responsible for payment in full of all charges and agree to provide a current credit card to be billed for my balances.

Type: (circle one) MasterCard or Visa. Name on Card: _____

Credit Card #: _____ Expiration Date: _____ CVV # : _____

Exceptions to this policy may be made in the instance of a documented serious medical emergency/illness or serious immediate family emergency.

I, _____, agree to the above described payment agreement, and

A) If billing to insurance: I request that payment of authorized insurance benefits be paid directly to Child and Adolescent Health Specialists, PC. I also authorize Child and Adolescent Health Specialists, PC to release all information necessary for the processing of insurance claims to HCFA, its agents or any other insurance company to determine the benefits payable for related services.

B) If paying privately/not covered by insurance: I agree to pay the fee of $150 at the time of service.

_____ Date _____