I authorize DSA Counseling Works, LLC to furnish information to their agents/insurance carriers concerning my treatment and hereby assign to DSA Counseling Works, LLC all payments for medical services rendered to me or my dependents. I also understand that I am responsible for any amount not covered by my insurance. I also understand that if a benefit is not covered, or a claim submitted on your behalf is denied by your insurance provider, you are personally responsible for payment of services rendered to you.

Date_____ Signature_____

DSA Counseling Works, LLC Financial Policy

Welcome to our practice! We are committed to helping you work within the framework of your insurance policy. Any questions regarding coverage must be directed to your insurance carrier, not the therapist. We will work according to the rules of your insurance carrier as we are instructed to do, but we have no control over what the carrier considers a covered benefit. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account, as it is our intent to never have the care of our patients compromised for financial reasons.

There are several important points to be made aware of:

1. Deductibles are the patient's responsibility. The deductible is determined by the contract you have with your insurance carrier. We do not know how much each person's deductible is and how much has been met at the time of your visit.
2. Co-insurance and co-pays are the patient's responsibility. They are to be paid at the time of visit or a surcharge of $10.00 for billing will be added.
3. We submit claims to your insurance, but you are responsible for responding to any questions from the insurance carrier for further information. Not doing so will result in a claim denial and you will be responsible for payment.
4. If the insurance payment is sent to you erroneously, you are responsible for forwarding payment to our office promptly.
5. In the situation where the patient's parents are divorced or separated, our policy is that the parent bringing the child for the office visit is the responsible party. We cannot bill the other parent.
6. Returned checks are subject to an additional fee of $25.00 to cover banking fees.
7. In the event that your account is sent to collections, you agree to pay for all related costs and expenses, including attorney's fees.
8. **Unless you cancel/reschedule your appointment within 24 hours of your scheduled appointment, a fee of $50.00 will be charged to your account. In the event of a "NO CALL NO SHOW," you will be responsible for the entire cost of your visit. Please help us serve you better by keeping your scheduled appointment.**
9. Someone with legal authority/guardianship must accompany all patients under the age of 18.
10. There is at least a $10.00 clerical fee for all forms needed to be completed.
11. If you have any questions about the above information, please do not hesitate to ask. We are here to help you. Thank you for reviewing our financial office policy.
12. **At any cost you must LATE CANCEL or NO CALL NO SHOW the unpaid balance is DUE BEFORE THE NEXT SCHEDULED SESSION.**

This page is front and back.

I have read the above financial policy, as well as understanding and agreeing to the terms and conditions of such.

Patient's Name: _____

Patient's Signature: _____

Date: _____

This page is front and back.