kp counseling

Client Financial Agreement

Client Name: Client#:

The following agreement states your financial obligation for psychotherapy counseling provided by kp counseling.

1. I am responsible for all fees incurred. Individual sessions are based on a 53+ minute session but may vary depending on the treatment needed at each session.

2. All fees are due at the time of service. You can choose to pay at the time of service yourself or have a credit card on file that will be charged on the day of service for any co-pays, deductibles, coinsurance, or self-pay rates due. If you choose to pay at the time of service and more than 3 payments are missed all future appointments may be cancelled until the account is made current or an auto payment plan is set up. kp counseling reserves the right to attempt to collect any unpaid bills by reasonable means. Non-payment of fees can be cause for termination from treatment.

3. We offer complimentary benefit checks for both in and out of network levels of care. When you make your initial appointment our intake team will ask for your insurance information so we can verify your benefits prior to your appointment. Our Insurance Verification Team will contact you to go over your insurance plan benefits and our contracted rates with your insurance company to explain what you will be responsible for paying. The benefits given to you are what we were quoted by your insurance company, and we cannot guarantee the accuracy of the information until we begin receiving the explanation of benefits. All quotes are not a guarantee of payment, and are subject to the terms, conditions, and exclusions of your health plan at the time of service.

4. Our contracted rates with your insurance company are subject to change at any time and may result in an increase in your out-of-pocket responsibility. We may not be aware of this change until the explanation of benefits (EOB), or explanation of payment (EOP) is received.

5. I understand if I opt out of using my insurance on the Consent for Treatment, I will be given a good faith estimate as required by the No Suprises Act.

6. I understand if I agree to using my insurance on the Consent for Treatment and decide later to opt out of using my insurance, I will need to complete a new Consent for Treatment or the Elect to self-pay for services form and will also be given a good faith estimate as required by the No Surprises ACT.

7. I understand it is my responsibility to obtain a PCP referral or insurance/EAP authorization if required by my plan.

8. I understand if there are any changes to my insurance, it is my responsibility to inform kp counseling. If I fail to report changes and update paperwork, I understand I will be responsible for all charges.

9. **Effective 01/01/24 no show appointments or appointments cancelled without two (2) business day notice will result in a $100.00 fee for psychotherapy services.**
   Your insurance company will not reimburse you for late cancellations or for not showing up for services. It will be your responsibility for payment at or before your next appointment. All cancellations must be made by phone. Emails and text messages are not acceptable for cancellations.

10. Clients who elect to only do telehealth sessions via video or phone must have a credit card on file. If you do not want to put a credit card on file, then only in person sessions are allowed.

11. If you wish to have any information provided to another doctor, family member for financial, scheduling, records, etc. you must fill out a Release of Information, sign, and date it. This Release is good for one year unless you request it be removed.

12. Clients who file bankruptcy: If we receive a letter from the Court discharging a client in a Chapter 7 Bankruptcy the account balance is written off to bad debt. If you want to continue or come back for therapy, we will verify your insurance benefits and payment must be made at the time of service for any amount responsible by the client. You will not be allowed the visit if payment is not made.

13. Return Checks: An NSF charge of $25.00 for any returned checks.

14. I understand kp counseling accepts payment by check or debit/credit card only.

15. **kp** counseling, ltd. Fee Schedule is available upon request.

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Client Name: Client#:

Client Name **DOB**

Responsible Party (if different than the client)

Responsible Party's Relationship to Client

Please Indicate your payment preference by checking either A or B below:

☐ A. I will pay myself at the time of service.

OR

☐ B. I authorize kp counseling to put my credit card on file to be charged for all services. **(List credit card detail below)**

I understand by putting my card on file it will be charged for all services due (deductible/coinsurance, co-pay, or self-pay amounts due as well as any missed appointment fees). I understand that if my insurance carrier also reimburses kp counseling I will be reimbursed for any over payment.

Name on card

Address City/State/Zip

Credit card number Phone#

Expiration date / 3-digit security code Zip Code

Signature of cardholder: Date:

I have carefully reviewed all the above statements regarding the Client Financial Agreement and accept all the above conditions as indicated.

Print Client Name DOB

Client Signature Date

Print Parent/Guardian Name (if applicable)

Parent/Guardian Signature (if applicable) Date

You may change your payment preference at any time by completing a new Financial Agreement. If you have any questions, please contact our Billing Department 779-368-0060 x 996.