Psychological & Counseling Centre, LLC

1201 South Main St., Suite 100
North Canton, Ohio 44720
330 244-8782
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www.vistapcc.com

FINANCIAL AGREEMENT Patient/Client Name: _____

IF YOU HAVE MEDICAL INSURANCE**:**
We will file claims to your medical insurance company for the services that are provided by our office. In order for the claims to process correctly, please ensure that the information that is provided to our office on the patient information form is accurate and current. If there is a change in insurance information please let us know immediately. We will submit to secondary insurance as long as we are given the correct information and we are notified that you would like this service done.

Deductibles, Co-Payments, and Coinsurance:
Co-payments are constant and due at the time the service is rendered. Coinsurance and deductibles vary for each insurance policy and we can only approximate the percentage covered by each plan. Payment of the estimated portion is due at the time of service.

Authorizations:
A copy of your insurance card is required at the time of the initial service. The card is descriptive and indicates whether an authorization is needed. Oftentimes, the behavioral health benefits are under a separate company and we must contact them to verify the necessity of an authorization. **If a copy of the card is not on the file at the initial service and the claim is denied for "no authorization," you will be responsible for the payment.**

Provider Coverage:
We are able to provide you with our list of providers who participate with your insurance company. However, we are not responsible for ensuring that our provider is covered under your particular plan provision. Each insurance company has multiple plans. The provider may participate with the insurance company, but not your particular plan. Please contact your insurance company to verify that the provider you are seeing is appropriately covered. **It is ultimately your responsibility to verify coverage for your particular plan. If the insurance company denies the claim for a plan provision, you will be responsible for the balance.**

Medical insurance coverage is a contract between you and your insurance company.
WE ARE NOT a party to this contract. We will not be involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. **You are ultimately responsible for the timely payment of your account.** In instances when a provider is out of network or you are opting not to use your insurance, you are entitled to protections of the No Surprise Act. An outline of those protections are provided on a spate form and also available on our website.

PAYMENT METHODS AND OTHER INFORMATION:

- We accept cash, check and VISA or MasterCard. (We add a 3.5% surcharge on all credit card payments. This surcharge is not greater than our total cost of accepting credit cards. There is no surcharge for debit card payments.)
- Accounts can be set up on payment plans if necessary at no additional cost.
- Accounts that are past due will be turned over to our collection agency and reported to the Credit Bureau.
- Accounts that have statements returned with no forwarding address will be charged $10 and turned over to a collection agency
- **All late cancellations and no-shows will be billed $50 automatically.** (We require 24-hour notice in advance to avoid charges.)

A SPECIAL NOTE: In situations of divorce, separation, court orders, etc., the party initiating treatment will be financially responsible for the account (including no-shows and late cancels).

We are committed to providing you with the best possible care and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

I acknowledge that I have read and agree to the above Financial Policy.

Signature: _____ Date: _____
Witness: _____ Date: _____