DESERT STREAMS, P.C.

FINANCIAL POLICY/ASSIGNMENT AND RELEASE FORM

Client Name _____ **DOB** _____

1. I, the undersigned hereby authorize the release of any clinical/medical information necessary for the processing of insurance benefits or Care Church Billing for Desert Streams Christian Counseling including medical and/or major medical benefits. I understand that regardless of my insurance coverage or lack thereof, I am responsible for payment of my account. IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, I AGREE TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES. This will insure that our responsible patients will not be penalized to cover costs incurred by those who do not pay on time. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

2. I authorize Desert Streams Christian Counseling to provide Associated Professional Billing, a billing agency, with whatever demographic, insurance and clinical information which is reasonable and necessary to obtain payment from both the insurance carrier and the responsible party.

3. Co-pays are due at the time of service. You will receive monthly statements with any balances after your insurance has been billed. If you have any questions regarding your charges or statement, please contact Associated Professional Billing at (269)362-4860. The balance of the account is due within 30 days. Desert Streams providers do not participate with straight Medicaid, nor are they allowed to participate with straight Medicaid. If Medicaid is your secondary insurance, you will be responsible to pay for all copays, coinsurances, and deductibles assessed by your primary insurance.

4. I acknowledge that I have received a copy of Desert Streams Christian Counseling Notice of Privacy Practices.

By signing below I acknowledge that I have read and agree to the Desert Streams Financial Policy.

Name: _____ Soc. Sec. #: _____
(Please Print)

X _____ _____ _____
Signature of patient, parent or legal guardian ***Date*** ***Relationship to patient***

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Desert Streams Christian Counseling for any services furnished to me by said provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown.

X _____ _____ _____
Signature of patient, parent or legal guardian ***Date*** ***Relationship to patient.***

RATES AND OTHER FINANCIAL ARRANGEMENT INFORMATION ON BACK

CHARGES

- **INITIAL ASSESSMENT $205.00**
- **FORTY-FIVE MINUTE SESSIONS $130.00**
- **ONE HALF HOUR SESSIONS $65.00**
- **SIXTY MINUTE SESSIONS $170**
- **(GROUPS OR TESTING - CHARGES VARY)**
- **$5.00 PER MONTH FINANCE CHARGES MAY BE ADDED IF AN ACCOUNT SHOWS NO PAYMENT ACTIVITY FOR OVER 120 DAYS.**
- **MISSED APPOINTMENTS WITHOUT NOTIFICATION MAY BE CHARGED AT $130.00. APPOINTMENTS CANCELLED LESS THAN TWELVE HOURS PRIOR MAY BE CHARGED AT $65.00.** *(VOICE MAIL IS AVAILABLE AFTER HOURS. WE UNDERSTAND SOME CANCELLATIONS ARE UNAVOIDABLE SO PLEASE GIVE US A CALL.)*

FINANCIAL ARRANGEMENTS

OTHER FINANCIAL ARRANGEMENTS (if applicable) **-** ***THERAPIST TO COMPLETE***

NO INSURANCE: CLIENT AGREES TO PAY $_____ PER SESSION.

OTHER ARRANGEMENTS:

_____

_____

_____

Client Name _____ **DOB**_____

X_____ _____ _____

Signature of patient, parent or legal guardian ***Date*** ***If signed by personal representative, relationship to patient.***

_____

Therapist Signature ***Date***