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 or Congregational Care benefits payable to myself or 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.

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

5. I acknowledge that I may use technology such as a cell phone, text message, or personal e-mail to communicate with Desert Streams or my clinician; however it may not be protected information.

CHARGES

- **INITIAL ASSESSMENT $250.00**
- **THREE QUARTER HOUR SESSIONS $150.00**
- **HALF HOUR SESSIONS $110.00**
- **ONE HOUR SESSIONS $220.00**
- **(GROUPS OR TESTING - CHARGES VARY)**
- **A 6% PER MONTH FINANCE CHARGES MAY BE ADDED IF AN ACCOUNT SHOWS NO PAYMENT ACTIVITY FOR OVER 90 DAYS.**
- **MISSED APPOINTMENTS WITHOUT NOTIFICATION MAY BE CHARGED AT THE FULL RATE LISTED ABOVE. APPOINTMENTS CANCELLED LESS THAN TWELVE HOURS PRIOR MAY BE CHARGED AT 50% OF THE FEE LISTED ABOVE.** *(VOICE MAIL IS AVAILABLE AFTER HOURS. WE UNDERSTAND SOME CANCELLATIONS ARE UNAVOIDABLE SO PLEASE GIVE US A CALL.)*

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***

2019 Rambling Rd. Kalamazoo, MI 49008 Phone: 269-345-0909 Fax: 269-345-4985

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.***

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***