FOCUS FORWARD
COUNSELING AND CONSULTING, INC.
SUPPORT | GROW | SUCCEED

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Our top priority is to provide you with the most effective and efficient services. Our automated payment program is intended as an advantage to you by streamlining the billing process and eliminating monthly statements, helping us to keep the cost of healthcare down. All payment related information will be held securely using key encrypted storage. You will always have the option to pay fees using another method at the time of service. Charges to your bank account or credit card will be determined as follows:

Copays/ Coinsurance / Deductibles / Self-Pay Charges - All fees are due at the time of service per your contract with your insurance company; self-pay charges are also due at the time of service. If an account balance remains after your insurance company has processed your claim (typically within 7-28 days from the date of service) the method of payment designated below will be automatically charged; ***we will attempt to contact you before charging a balance of greater than $200.***

Late Cancellation or No-Show Charges - These charges are generated by your provider if you fail to show up for a scheduled appointment, or if you do not give adequate notice (two business days) for cancelling an appointment you will be assessed an $85 fee. If you incur such a charge your authorized method of payment will be charged. Please note that cancellation and no show fees are not eligible for HAS reimbursement.

Late Cancellation or No-Show Charges for Psychological Testing - Testing consultation and administration services require a significant period of time to be reserved for you. We require that the intake session, in person testing appointments, and feedback sessions are paid via advance deposit. In the event that you are unable to keep an appointment, you must notify your clinician at least two business days in advance. If such advance notice is not received, you will be financially responsible for the time reserved. For intake sessions and feedback sessions (1 hour), the late cancellation/missed appointments fee is $85. As psychological and educational testing requires more extensive blocks of time to be reserved the late cancellation and missed appointment fees are as follows: Academic Screener - $150; General Psychological Evaluation - $250; ADHD Evaluation - $250; Psychoeducational - $500.

Insurance - Your health benefit plan is an arrangement between you, the enrollee and the insurance company, HMO or your employer. While we will try to be helpful, and we may participate in the plan, your health benefit plan determines your coverage, any requirements for prior authorizations or referral establishes the limit on your coverage for mental health services. We cannot know the benefits and exclusions of each client's policy. It is your responsibility to know and understand your coverage and benefits including deductibles, co-payments and/or co-insurance. Even when such eligibility and/or benefits are verified by Focus Forward, your insurance plan will not guarantee its accuracy. It is also your responsibility to know if your insurance has rules or regulations for referrals from primary care physicians, pre-certification, limits on outpatient charges, or specific physicians and/or clinics to use. You agree to accept responsibility for co-payments, deductibles, and other services that are provided to you which are not specifically covered by your insurance plan or denied due to the absence of authorizations/referrals you are obligated to obtain under your insurance plan.

Non-covered and denied charges - A non-covered service is any service that is denied by your insurance carrier due to benefit descriptions or limitations, policy exclusions, or pre-existing waiting periods. Non-covered services

denied because they fail to meet the insurer's standards of medical necessity. Relationship issues such as couples or marriage counseling often will be denied due to not being medically necessary. Denied services will be the responsibility of the client.

Updating Information - Please be sure we have the most current demographic and insurance information at all times. It is your responsibility to provide us with this information. The information you provide us must match the information you provide the insurance carrier. Filing insurance claims with the wrong information delays processing and may increase the client's financial responsibility. Please note that if you fail to provide us with correct insurance information, we will not re-file a claim to the correct insurance after 30 days and the balance will become your financial responsibility.

Method of Payment - ***We would greatly appreciate your choice of our ACH Option***. This process will debit charges from your checking account and helps to keep the cost of healthcare down by reducing transaction fees. If ACH is not viable please choose our credit card option.

ACH Option - Checking Account
Bank/Credit Union Name _____
9 digit Routing Number_____ Account Number_____

Credit Card Option
Account Number_____ Exp. Date___/____ Security Code_____
If the above credit card number is from an HSA/HRA account please also furnish a backup credit card. This card will only be charged if the above card is declined.

Backup CC Account Number_____ Exp Date___/____ Security Code_____

Client Name (printed) _____ Card/Account Holder Name_____
Billing Address _____ City, State, Zip_____

By signing below, I authorize Focus Forward Counseling and Consulting, Inc. to charge the payment method indicated in this authorization form. I certify that I am an authorized user of the bank account or credit card and that I will not dispute the payment with my credit card company or banking institution so long as the transaction corresponds to what has been indicated in this form. We reserve the right to use a collection agency to collect outstanding debts and the right to terminate services. Reasonable collection and/or attorneys fees may be incurred for the collection of unpaid balances. Should a balance be placed in collections you will be responsible for collection fees. In the event collection services are utilized, protection of private information is not guaranteed.

Signature_____ Date_____

- ❑ Please check this box if you would like all your previously accrued balances prior to today's date charged to this same payment method.