



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** - 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 a \$75 fee. If you incur such a fee your authorized method of payment will be charged.

**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 will be the responsibility of the client and payment is due at the time of service. Similarly, some charges will be 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 \_\_\_\_\_

A \$10 fee will be incurred for ACH returns and reversals of payment for insufficient funds or inaccurate account information.

**Credit Card Option**

Card Number \_\_\_\_\_ Exp. Date \_\_\_/\_\_\_ Security Code \_\_\_\_\_

If the above credit card number is from an HSA/HRA account please also furnish a backup credit card. The backup card will only be charged for non-qualified expenses such as a no show or cancellation fee, or 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. In the event collection services are utilized, protection of private information is not guaranteed.

Name (please print) \_\_\_\_\_ Date \_\_\_\_\_

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.