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

5975 Parkway North Blvd., Suite 300 D
Cumming, GA 30040
www.focusforwardcc.com

(p) 404-388-3909
(f) 678-712-1945
admin@focusforwardcc.com

Financial Policy & Agreement

Authorization to Charge Credit/Debit Card for Insurance Denials and Non-Covered Services

We recognize the need for a definite understanding between you and your clinician concerning healthcare and the financial arrangements for this care. Our commitment is to provide the very best clinical services to our clients while recognizing the need to limit services to only those that are medically necessary. The responsibility for payment of fees for these services is the direct obligation of the client.

Insurance:
You must realize that 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 the client's responsibility to know and understand his or her coverage and benefits. We will seek to obtain verification of your eligibility; however, even when such eligibility and/or benefits are verified, your insurance plan will not guarantee the accuracy of their confirmation of coverage or benefits, and that you are eligible and that your benefits are in force. It is also your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals from primary care physicians, pre-certification, limits on outpatient charges, specific physicians and/or clinics to use. You should be knowledgeable of any deductibles, co-payments and/or coinsurance. You agree to accept responsibility for copayments, deductibles, and medical care and other services that are provided to you which are not specifically covered by your insurance plan or not covered due to the absence of authorizations/referrals you are obligated to obtain under your insurance plan. The services, plans, and benefits under your insurance plan may be subject to and governed by applicable contracts and government regulations. This agreement is not intended to conflict with or circumvent the provisions of such contracts and regulations, including any provision regarding grievance procedures that may be available to you.

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 preexisting 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, 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.

ACCEPTANCE OF POLICY:
I have read and do understand the contents of this form and am authorizing FFCC to charge my credit or debit card should my insurance company deny reimbursement for services rendered.

CREDIT /DEBIT CARD INFORMATION:

VISA#_____ _____ _____ _____ CV CODE _____ EXPIRATION DATE _____

MASTERCARD# _____ _____ _____ _____ CV CODE _____ EXPIRATION DATE _____

NAME ON CARD_____

BILLING ADDRESS_____

_____

Please sign and date your name below indicating that you have read and understand the contents of this form.

_____ _____
Client name (please print) Date

_____ _____
Client signature Date

If Applicable:

_____ _____
Parent's or Legal Guardian's name (please print) Date

_____ _____
Parent's or Legal Guardian's signature Date

The signature of the counselor below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

_____ _____
Clinician’s signature Date