Financial Responsibility Agreement

Insurance Coverage: We will communicate an estimate of insurance benefits at the onset of treatment. We strongly encourage you to contact your insurance company to verify your coverage. This estimate of benefits is not a guarantee of coverage, and you are ultimately responsible for any fees not paid by your insurance plan.

If Private Health Insurance Covers the Treatment: If private health insurance covers the treatment, PPH will submit both bills directly to the insurance company or plan. Although PPH will bill the company or plan for the full amount of the list charges, the company or plan may have a contract with PPH that provides for PPH to accept, in payment of the bill, amounts that are discounted from the list charges as stated on the bills.

Your insurance coverage may provide that some amount of both of these bills will remain your personal responsibility. If that is the case, the insurance company or plan will notify both PPH and yourself of how much of each bill remains your responsibility. PPH will then bill you for those remaining amounts and you will be responsible for paying them.

Please note that PPH does not know the terms of your insurance coverage and cannot tell you in advance either what the exact amount of either bill will be or what part of either bill will end up being your personal responsibility. If you have questions about the action your insurance company or plan takes on these bills, please contact the company or plan.

If your insurance company or plan denies coverage of either of the bills, or if it does not act within a reasonable period of time on the claim to pay it, PPH will have the right to require you to pay the entire bill. If any part of these bills is your responsibility to pay, you may be eligible for a financial plan to help you with that obligation.

Assignment of Benefits: If the treatment is covered by insurance, you authorize and direct the insurance company or plan covering the treatment to directly pay PPH. If the insurance company or plan makes the proper payment in compliance with its obligations of your insurance plan, it will have no further responsibility toward you or toward PPH with respect to the bills.

Copayments: You may have a copayment, which is a fixed payment due at the time of service.

Coinsurance: You may also have to pay co-insurance, which is a percentage of the session fee unpaid by your insurance company.

Deductibles: You are responsible for full payment of fees until your deductible amount is met.

Cancellations and No Show Appointments: Once you are scheduled for a regular therapy appointment, you will be expected to pay for that session each week.
PPH has a right to charge your credit card $100.00 (one hundred dollars) for all missed without appropriate notice appointments and all No-Show Appointments. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. Therefore, you will be charged the full fee for a missed appointment, and not only your co-pay amount. By law, you are responsible for the full payment of cancelled session fees.

Collection Costs and Fees:
Failure to make payments as provided by this agreement will result in a default of the agreed payment schedule. If PPH is required to forward the defaulted balance to a collection agency or an attorney for recovery , the patient agrees to pay all costs of collection, collection fees, court costs and reasonable attorney fees.

We recognize that family's lives are increasingly busy and scheduled. We are available to work with you so that you or your child can still have the benefit of consistent weekly appointments; we will always do what we can to reschedule your appointment during the same week or schedule a phone session. Keep in mind that treatment is most effective when it occurs at the regularly-scheduled time each week. Therefore, whenever possible, it is best to try to protect your scheduled time.

Authorization to Discuss Medical Information: It may be necessary for PPH to disclose your medical information (also known as protected health information) to physicians, nurses, and other healthcare professionals in connection with your treatment; to insurance companies and plans in connection with obtaining payment for your treatment; and otherwise as permitted by law. Please understand that, by signing this form, you authorize PPH to release both routine and sensitive medical information, including, for example, information relating to AIDS/HIV, mental health treatment, or drug and alcohol abuse. PPH will make reasonable effort to limit disclosure of protected health information to the minimum necessary to accomplish the intended purpose.

Questions: If you have any question about this document, we encourage you to consult with your clinician before you sign it. If you are insured, we also encourage you to talk to your insurance company or plan about any questions you have about how your bill will be covered under the terms of your coverage.

Please sign the next page to acknowledge your consent to these policies. Please retain this copy of the agreement for your records.

Consent to Financial Responsibility Agreement

In signing this form, you agree to PPH's Financial Responsibility Policies outlined for you.

You also grant permission for the credit card account on file to be charged per the policies outlined above.

Name (print)	Client Name (If different)
Signature Date	Witness Date

Please return this signed form to your Intake Clinician