

## Center for Cognitive Therapy

(860)-677-2991

### Financial Policy Statement

Thank you for choosing us as your behavioral health care provider. We are committed to you or your family's treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign in order to receive ongoing treatment.

#### *Payment for Services*

**Co-payments and or full payment of deductible are due at time of service.** Our fee is 130.00 / session which can run from 50 minutes to an hour. Some insurance companies will ask that you wait for an EOB. Our policy doesn't support that, so if you choose not to pay at time of service please feel free to find another health care provider. We accept checks, cash or credit card and ask for a **copy of a credit card** at the initial session. We would like to continue taking some insurances, therefore if a co-pay or deductible is not paid at time of service, \$20.00 will be charged for every bill sent. Please know your insurance company payments and policies. Expecting the therapist to do that work is outside of our obligation to you.

#### *Statement about insurance*

We do accept assignment of many insurance benefits. We do provide receipts indicating the appropriate diagnosis, the type of treatment received, and the amount that has been paid for sessions if receipts are requested. If you want a receipt please make that known to the therapist at the beginning of the session so that the proper amount of time can be allotted. We recommend that you become familiar with your mental health benefits in regards to seeking reimbursement for out of network provider. If you need authorization and do not get it prior to a session beginning, you will be charged the fee of \$130.00 / session.

#### *Prior to the first appointment*

Please call the behavioral/mental health number on the back of your card to find out what your behavioral health coverage includes. You the client will be responsible for fees due to no authorization, as well as deductibles. For all deductibles, the payment is expected at time of service.

*Usual and Customary Rates*

Our practice is committed to providing the best evidence based treatment. Scheduled sessions are 50 minutes in length. Please try to respect that limit as therapists benefit from a few minutes alone between clients.

*Minor patients*

The parents (or guardians of the minor) are responsible for full payment. In those cases where minors arrive at the office unaccompanied, arrangements should be made to have payment made at time of service.

*Missed Appointments*

Unless cancelled at least 24 hours in advance, our policy is of charge for missed appointments at the rate of a normal office visit which is \$130.00. Please help us serve you and others by keeping scheduled appointments. We wait 15 minutes for late clients and then assume that they are not coming and move on to other business.

Thank you for understanding our financial policy Please let us know if you have any questions or concerns.

I have read, understand, and agree to this Financial Policy.

\_\_\_\_\_  
Signature of Client or Responsible Party

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Co-Responsible Party

Date \_\_\_\_\_