Eating and Behavioral Health Associates, LLC

4041 N. High St, Suite 300D
Columbus, OH 43214
614.431.1418

FINANCIAL AGREEMENT

I understand that payment is due at time of service. I understand insurance coverage varies, and that it is my responsibility to know which outpatient psychology services are covered, and the extent of my payment responsibility. A credit card may be placed on file and be charged the day of the session or at the beginning of the session. You may provide this information on the Credit Card Consent Form.

Failure to pay for a session will result in no further scheduled appointments until balance is paid in full.

I understand that I will be charged for missed appointments unless I provide 48 hours (2-day) notice of cancellation, unless we both agree that I was unable to attend due to circumstances beyond my control. My credit card will be kept on file and will be charged in the event of a late cancelation (< 48 hrs) or a no-show. The fee for the first late cancellation/no-show is $175 and the charge for missed sessions thereafter will be the full fee of $250.

Payments can be made by cash, check or credit card prior to the start of the session. If I fail to make payment by the end of the session, my session will be charged to the credit card on file.

I understand that I am legally responsible for all charges for services provided. Should my account be referred to a collection agency/attorney, I will be responsible for any additional associated fees.

I understand that if I or a family member arrive to session impaired by a substance, my appointment will be rescheduled, and I will be charged the full session fee.

I authorize my provider (Eating and Behavioral Health Associates, LLC) to release information required by the insurance company to process claims for the payment of benefits.

I will alert my therapist to any changes to the insurance information that will impact payment of my benefits and provide information such that billing can be processed.

I understand that I will be charged a $35 returned check fee if I pay by check and the funds are not available in my account to honor my check.

Regarding Insurance:

Eating and Behavioral Health Associates. LLC may accept assignment of insurance benefits after confirming coverage. However, confirmation or authorization of benefits is not a guarantee of payment for services.

In the event that your insurance company rejects the claim or does not pay in full (or contracted rate) for all services rendered, you are responsible for payment in full (or contracted rate). You are responsible for non-covered services, deductible amounts, co-insurance and co-payments. You are responsible for notifying Eating and Behavioral Health Associates, LLC if your insurance coverage changes, or of any secondary insurance coverage. Failing to notify may result in owing payment in full.

Eating and Behavioral Health Associates, LLC does not bill **secondary insurance** (unless you are covered by Medicare). You may bill any secondary insurance on your own, and be reimbursed directly. However, you are responsible for any payments owed to Eating and Behavioral Health Associates, LLC not paid by your primary insurance.

I understand that this form is valid unless I cancel or change the terms of authorization through written notice.

I have read, understand, and accept payment policies described in the above agreement. The fee for which I agree to assume responsibility is:

- **Contracted co-pay/co-insurance rates per in-network insurance policy**
- 55-minute Psychotherapy session $250
- 75-minute Assessment/intake $275

- Report Writing (Includes letters or any other documentation needed by patient completed outside of session time) $100 per 30 minutes
- Phone calls lasting more than 10 minutes are prorated at psychotherapy session fee $250

MY SIGNATURE INDICATES THAT I HAVE READ THIS AGREEMENT AND AGREE TO ABIDE BY ITS TERMS.

_____ _____

Signature of patient or authorized representative Date

_____ _____

Signature of parent of a minor child Date