Billing Information and Policy

Our billing policy for services, which are the client's responsibility, is as follows:

Please initial each item:

_____ All co-pay, co-insurance, sliding fee scale, payment lan, and deductible amounts are due on the date of service. If client payments are not made on the date of service, or if arrangements for an alternate payment plan have not been made, charges will be submitted to the client credit or debit card on file in our office.

_____ Clients will not receive a statement for services that are the responsibility of their insurance company. Clients will not receive a statement if their balance has been paid in full on each date of service, and their account is current.

_____ Any psychological services that are not eligible for coverage through a client's insurance plan or EAP, become the responsibility of the client. If not paid on the date of service, these charges will be submitted to the credit card on file either on the date of service, or on the date we receive notice that services have been denied. Receipts for all credit or debit card transactions will be mailed to clients along with their statement.

_____ A late cancel fee will be submitted to the credit of debit card on file for clients with private insurance coverage, a payment plan, or sliding fee scale, which includes cash clients. This charge is submitted on the date of service only if clients misses an appointment without giving a 24-hour notice to cancel or do not show up to a scheduled appointment without 24-hour notice.

_____ By signing you agree that: I understand that if I default on any payment obligations as called for in this agreement, Reimann Counseling Clinic will have the right to forward my information to collections. I understand and give my consent for Reimann Counseling Clinic to forward my information to collections, should I default on this agreement and fail to pay my Balance Due.

Credit Card Information

We require all clients to keep a credit card on file in accordance to the above billing policy.

Name on Credit/Debit Card: _____

Address of Card Holder: _____

Credit Card Type: Visa: _____ MasterCard: _____ Discover: _____ American Express: _____

Card #: _____ Exp Date: _____ 3 Digit # on Back of Card: _____

I acknowledge I have been informed and agree to the above billing policy. I understand that payments are due on the date of service. I agree that Reimann Counseling Clinic may bill the credit card on file for any payments which are my responsibility, that have not been paid on the date of service. I hereby consent for Reimann Counseling Clinic to utilize my credit card information for any outstanding balance.

_____

Signature of Credit Card Holder, Authorizing Payment

Medical Care

Clinic Doctor's name: _____ Phone: _____

Address: _____

Are you on any medications, if so, please indicate name and dosage: _____

_____

If you enter treatment with us for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

Emergency Information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Clinic Information and Client Consent Policies

Overview of Therapy

Therapy varies depending on the therapist, the client, and the client's particular situations and goals. Your therapist may use many different methods to deal with your particular situations and goals. In order for therapy to have the best outcome, you will likely have to invest energy into the process and work actively on things we talk about during and between our sessions.

Therapy can have benefits and risks. The risks may include experiencing uncomfortable feelings like sadness, guilt, anger, anxiety, or frustration when discussing aspects of your life or relationships. Research shows psychotherapy to have benefits that can include better relations, solutions to specific problems, increased life satisfaction, improved physical health, and significant reductions in feelings of distress. However, it is impossible to predict or guarantee what you will experience.

Your first few sessions will involve an evaluation of your situation and needs. We will also discuss your goals. During this time, you and your therapist together will decide if your therapist is the best person to provide you with therapeutic services. Therapy can involve a significant investment of time, energy, and money so it is important you select a therapist you are comfortable working with. If at any time you have questions about any aspect of your work with your therapist, please discuss with your therapist. If you decide you do not want to continue in therapy, please inform your therapist. If you want help finding another therapist or other appropriate resources, we will happily assist you in doing so.

Crisis Response and Contacting Your Therapist

Your therapist is often not immediately available by phone because we do not answer the phone when in session with clients. Feel free to leave a voicemail and your therapist will get back to you within the next business day (Monday through Friday). We will make every effort to return your call as soon as possible (usually within a few hours and almost always within 24 hours Monday through Friday). If you are difficult to reach, please let us know in advance. When your therapist will be unavailable for an extended time, you will be provided with a backup therapist to contact if necessary.

Outpatient mental health services are consultative in nature; we are not equipped to handle emergencies. Please call the Crisis Connection 612-379-6363, Community Outreach for Psychiatric Emergencies (COPE) 612-596-1223, 911 or go to the nearest hospital emergency room if you are in crisis.

Financial Responsibility

Most health insurance plans include behavioral health coverage, however, the exact coverage varies widely with the different health insurance plans. Clients are responsible for services received not covered by insurance; therefore we strongly recommend you call your insurance company to verify coverage. When you call your insurance company, ask to verify your coverage for outpatient mental health. It is also your responsibility to keep us up-to-date with any changes in your benefit plan and / or insurance coverage.

Cancellation Policy

Please give a 24-hour notice if you will not be able to keep an appointment. If you do not give a 24-hour notice, you will be charged $100 – which is not billable to insurance companies. Please phone us with cancellations as soon as possible to avoid late cancellations fees, and out of respect to others who may need that appointment time.

Cases Involving the Legal System

Our services are not to be utilized for testimony, custody disputes, disability or any other form of court evaluations. We are happy to refer you to other providers in the area who provide these services should you require any court evaluation or testimony. Should we be subpoenaed or mandated by the courts to testify, you will be required to pay all fees associated with the writing of case summaries and/or other reports, consultation with mental health professionals, review of other records, and any other preparation. The client will also need to pay for other fees incurred including travel time, meals, parking and all other costs associated with the court time. Therapist testimony will require the client be billed directly, as insurance will not cover these charges. All fees must be paid prior to the date of testimony. Court appearances are significantly more expensive due to the complexity and difficulty of being involved in such matter.

Rates

Billing Code	*Service*	*Length of visit*	*Fee for service*
90791	Intake	45-50 minutes	$215
90834	Psychotherapy 45 minutes	38-52 minutes	$150
90837	Psychotherapy 60 minutes	53 minutes plus	$160
90847/90846	Family/Couple Therapy	45-50minutes	$160
Billed to Client	Late Cancel/No Show	N/A	$100

Reimann Counseling Clinic reserves the right to change the policies, practices, and procedures described in this document. We will notify you in writing of any significant changes. My signature below indicates I am consenting to treatment at Reimann Counseling Clinic, and have received and understand the contents of the clinic's counseling Policies, including the Notice of Privacy Practices (HIPAA). If I have questions, the information has been explained and/or summarized for me.

_____ _____

Signature (Client of Legal Guardian is client is under 18) Date

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My signature below certifies my consent to the billing and payment policy. All of my questions have been answered and the policy regarding billing is fully agreed to. I also, by signing below, consent to taking full responsibility for any outstanding bill for services rendered. I also agree that my signature authorizes Reimann Counseling Clinic to pursue any outstanding balance due to them should I not follow the clinic policy.

_____ _____

Signature (Client of Legal Guardian is client is under 18) Date