TRUE SELF COUNSELING SERVICES

FINANCIAL POLICY

PLEASE READ CAREFULLY

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

PARENT/GUARDIAN'S NAME (IF PATIENT IS A CHILD)**:** _____

Please write your initials next to each line, indicating that you've read and understood each policy.

_____ **Patient Financial Policies**

Self-Pay Patients and/or Out-of-Network Patients:

- It is your responsibility to provide payment prior to entering your session.

In-Network Insurance Patients:

- We bill the insurance carrier for you if proper paperwork is provided to us. Any outstanding balances, co-payments and deductibles, are due prior to your appointments. Additionally, if you receive any insurance payments directly from your insurance carrier for services performed, you are responsible to pay such payments to *True Self Counseling Services*. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you.

_____ **Signatures on File and Assignment of Benefits Agreement**

- Patient authorizes the release of any medical information necessary to process their insurance claim.

_____ **Methods of Payment Currently Accepted**

- Cash; Credit / Debit Cards; Personal Checks (A $25 Not Sufficient Funds (NSF) charge will apply for returned checks).

AT THE PATIENT'S DISCRETION, A CREDIT/DEBIT CARD MAY BE LEFT ON FILE TO BE CHARGED AFTER EACH APPOINTMENT. IF YOU CHOOSE TO DO SO, PLEASE COMPLETE THE FOLLOWING INFORMATION

*****WE ACCEPT VISA, MASTER CARD, DISCOVER & AMERICAN EXPRESS*****

Please Note: We DO NOT Accept Medical Payment cards at this time
(i.e. CareCredit, Citi Healthcard, Wells Fargo Health Advantage Card)

CARD HOLDER'S NAME (*AS PRINTED ON CARD*) _____

CARD NUMBER _____

EXPIRATION DATE (*MM/YYYY*) _____ **CVV CODE** _____

BILLING ADDRESS _____ **ZIP CODE** _____
(ASSOCIATED WITH THE CARD)

*I authorize **True Self Counseling Services** to charge my credit card for the amount owed after each psychotherapy / testing session.*

CARDHOLDER'S SIGNATURE: _____ **DATE:** _____

10637 NORTH KENDALL DRIVE, SUITE 7F
MIAMI, FL 33176

(786) 393-2236
INFO@TRUESELFCOUNSELINGSERVICES.COM

TRUE SELF COUNSELING SERVICES

_____ **Cancelation Policy:**

- Because my time has been reserved exclusively for me and/or my family members, I understand that I am required to provide **at least 24 hours** advance notice if unable to keep the scheduled appointment. In the event that I do not provide 24 hours advance notice, I am financially responsible for the reserved appointment. **There is a $50.00 cancelation fee per appointment reserved regardless of insurance.** If you have a credit card on file, the credit card will be charged for your cancelation fee unless otherwise specified. Exceptions may be considered for emergency situations.

Additional Fees For Services That Are Not Covered By Insurances

Upon prior discussion and agreement, I understand that charges will be added to account for additional services rendered **not** billable to insurance carriers such as:

- Telephone contacts exceeding 15 minutes.
- Preparation of letters or reports.
- Preparation and review of medical records.
- Court time (portal to portal) including preparation, travel, and wait time.
- Additional meetings with other family members and/or professionals.
- Scoring of material, interpretation and report writing.
- Excessive email correspondence.

If not paid according to the above terms, the patient understands that our office may report to an outside collection agency. In the event that your account is turned over for collections, patient agrees to pay all additional fees accessed in the collection of the debt.

I have read, understood, and agreed to the above financial policy for payment of professional fees.

SIGNATURE: _____ DATE: _____

10637 NORTH KENDALL DRIVE, SUITE 7F
MIAMI, FL 33176

(786) 393-2236
INFO@TRUESELFCOUNSELINGSERVICES.COM