RIEGLER, SHIENVOLD & ASSOCIATES
FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is a statement of our financial policy. Please read and sign prior to any treatment.

Insurance Benefits and Billing

We participate in several major insurance companies and mental health managed care networks. We will submit the mental health services claim to your insurance carrier if you have given us all of the required information. We must have *correct* policy, group, ID or claim numbers along with a correct billing address. Please be aware that some and perhaps all of the services provided may be "non-covered" or deemed "not medically necessary" according to your policy. You will be responsible for payment of the deductible, copay, coinsurance or non-covered services at the time of service. It is the patient (or the responsible party's) responsibility to confirm that the treating therapist is in the insurance network and obtain pre-authorization or pre-certification for services, if required by the insurance company.

We will attempt to determine your benefits by contacting your insurance company via phone or online. The information provided to us may or may not be correct. You will be responsible to pay any amount due to us after your claim has been finalized. We encourage you to contact your insurance company to verify your benefits.

Minor Patients

The parent / guardian / adult accompanying a minor child is responsible for payment at the time of service. In cases of divorced or separated parents, the parent who brings the child in for services is ultimately the responsible party. If there is a court order in effect, and payment is not made *in advance* by the party responsible per the court order, payment *must be* made at the time of service by the adult accompanying the minor and reimbursement will be the responsibility of the parties involved. If both parents have insurance, please check with your insurance companies to determine which company is the primary carrier.

OUR BILLING PROCESS

- If your claim is **denied**, the balance due for services will be your responsibility. You will receive a statement for any amount due. If payment is not made by the date due on the statement and it becomes necessary to send another statement, a $20.00 billing/statement fee is applied to the account.
- If we **do not received a response** from your insurance carrier within 31 - 60 days of claim submission, we will submit a second claim.
- If we do not receive a response from your insurance carrier within 61-90 days of claim submission, you will receive a statement and will need to contact your insurance carrier regarding payment. The balance due for services will be your responsibility.
- A billing statement will be mailed to you. Payment is due as indicated on the statement. The billing/statement fee applies as above.
- If your account becomes delinquent, it will be placed with a collection agency. Patients are then responsible for any collection costs.
- If your account is in collection, any appointments you have scheduled will be cancelled and no further appointments will be made until the balance is paid in full. We reserve the right to bill in advance for scheduled appointments for those accounts that have previously been in collection.

Any child 18 or over is legally an adult and responsible for his/her bill. (Regardless of attending college, living at home, or being covered by parents' insurance.)

Payment

Please note all copays/coinsurances are due at the time of service. If we must bill you for a copay, a $20.00 billing fee will be assessed. We accept cash, checks, VISA, MasterCard, Discover or Debit Cards as payment. In the event that a personal check is returned unpaid from your bank, your account will be charged a $25.00 returned check fee and turned over to the District Justice if not reconciled promptly. Balances owed from previous visits are expected to be paid in full at the time of your appointment..

Late Cancellations/Missed Appointments

If your appointment is not cancelled at least ***24 hours*** in advance, you will be charged for the appointment time reserved for you. Please help us serve you and others better by cancelling appointments at least 24 hours in advance.

I have read the above financial policy. I agree to this financial policy.

_____ **Date:** _____

Signature of Patient or Responsible Party(s)