ALPHABET SHUFFLE, LLC

Client Name:_____ Date Of Birth:_____/_____/_____

Financial Policy

Thank you for choosing Alphabet Shuffle, LLC for your out-patient mental healthcare. We are committed to providing you with quality care. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will submit claims to insurance companies and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers.

Payment is due at the time of service. We accept cash, checks, and debit/credit cards.

Insurance

All clients must complete our patient information form before seeing a therapist. We must obtain a current, valid insurance card to provide proof of insurance. If your insurance changes, please notify us before your next visit so that we can make the appropriate changes to help you receive your maximum benefits. If you fail to provide us with the correct insurance information in a timely manner, you are responsible for the balance of the claim.

We participate in most insurance plans. You have a contract with your insurance company. We are not a party to that contract, and while we do our best to obtain information from your insurance company, it is ultimately your responsibility to understand your policy and its limitations. When we accept your insurance, you are still responsible for charges in full for all treatment. If you do not have insurance, we charge $75.00 per session with payment due at time of service.

Co-payments and Deductibles

If you have insurance, the payment of your deductible and estimated patient portion is due at the time of service. We will give you our best estimate of what the co-pay should be for each visit. For many policies, the co-pay may change during your course of treatment and insurance plans change without notifying providers. The only way we can confirm exactly what a co-pay should have been is by reading the materials that come to us from the insurance company after the session is billed and paid. Most insurance companies will send you a copy of this Explanation of Benefits (EOB) or have you log into your account with their company. If your co-pay was higher than collected, you are responsible for paying the difference. If it should have been lower, we will give you a refund or credit.

The accompanying parent or adult is responsible for full payment at the time of service. In the case of divorce, please do not place our office in the middle of marital disputes. It is your responsibility to work out the payment of your child's mental healthcare between the custodial and noncustodial parent. Subsequently, bills will be sent to the address of record and the parent who lives at that address will be responsible for payment.

Payment arrangements are available. However, it is up to you to ask for this service. It is your responsibility to adhere to any payment arrangements. If you fail to make your payments as your contract states, Alphabet Shuffle, LLC, may null and void the contract with full payment expected. Please be aware that if no payment is made within 90 days of service and no payment arrangements are made, our policy is to refer your account to Associated Collectors, Inc. You will be required to reimburse Alphabet Shuffle, LLC any collection agency fees, which may be based on a percentage at a maximum of 30% of the debt, and all cost, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Other Professional Services

There may be additional fees for other professional services (ADHD assessment, basic mental health assessment, letters and/or reports necessary for lawyers, doctors, school personnel, consultation with attorneys, etc.) asked for and rendered by Alphabet Shuffle, LLC.

- You are responsible for other professional services (letters and/or reports necessary for lawyers, doctors, school personnel, consultation with attorneys, etc.) asked for and rendered by Alphabet Shuffle, LLC. The standard fee that will be charged for these services is $125.00 per hour.
- You are responsible for covering Alphabet Shuffle, LLC's fees for expert testimony or depositions. This fee includes pre-court or pre-deposition reading and preparing for court or deposition, waiting time to testify, and time on the stand. The standard fee that will be charged for these services is $500.00 for AM or PM sessions or $1000.00 for the entire day, not including mileage. These fees will apply if the therapist testifies for 1 minute, the entire day, or not all. The fees will apply if the court or deposition is canceled or postponed and we do not receive a 24 hours' notice (1 business day, not including holidays or the weekend). These costs are not billable costs to your insurance company.
- You are responsible for covering the costs of ADHD testing asked for and rendered by Alphabet Shuffle, LLC. If you do not have insurance, the standard fee that will be charged is $200.00. This includes ADHD testing time and the written report sent to your referring physician. Payment is expected at time of service, or you will not be seen for testing.

Non-covered Services

You agree to provide total payment for out-patient mental health therapy and other services requested and rendered by Alphabet Shuffle, LLC, including any treatment not deemed to be a benefit by your insurance.

Missed Appointments/Late Cancellations

Missed/Late Cancelled appointments represent a cost to us and to other patients who could have been seen in the time set aside for you. If you cancel an appointment 24 hours in advance, no charge will be made. Without this advance notice, you may be charged $45.00 per cancellation. This fee must be paid before any other appointments are made. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. If you do not show for an appointment, you may be charged $45.00 per No-show. This fee must be paid before any other appointments are made. If you no-show/no-call for an appointment, all future scheduled appointments will be cancelled. If you No-show for 3 appointments in a 12-month period of time, without calling to cancel, you will be discharged from Alphabet Shuffle, LLC.

Other Charges

Returned check charge. A $25.00 fee will be charged for any checks returned for insufficient funds. We will not accept additional checks if two (2) are returned.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

_____ _____

Responsible Party Member's Name Relationship

X_____ _____/_____/_____

Responsible Party Member's Signature Date