Abundant Solutions, LLC
Insurance Release and No Show/Late cancellation

Client Name _____ Social security Number _____

Name of Insured _____ Primary Insurance _____

Insured Date of Birth _____ Relationship to Patient _____

Employer _____ Work Phone _____

We are fully committed to helping you accomplish the goals you establish when you enter counseling, to help you maximize your investment of time and finances. We will deal with you fairly, equitably and with sensitivity in financial matters. We believe that a clear understanding of our financial policies is important for both client and therapist. The following information is presented with this in mind. A copy for your records will be provided upon request.

Office Financial Policy

As a courtesy to you, our office will bill your insurance company. However, there are numerous insurance networks and we may or may not be a network provider. If not in-network, we may not have agreed to accept a reduced fee from your insurance company. It is the responsibility of the patient to know and understand the benefits of your insurance plan. Our office does not accept/file to secondary insurance. It is the insured's responsibility to file and accept all payments insured by secondary insurance. Insurance coverage is a contract between the patient and their insurance carrier. We will assist you in maximizing your insurance benefits by verifying your benefits prior to your first visit; however, this is not a guarantee of benefits or payment. By law, the insurance carrier must remit payment or deny the insurance claim within 30 days of the initial notice of claim. If an insurance problem occurs, the patient may be asked to assist our office in contacting the carrier and/or filing a complaint with the State Insurance Commissioner.

Insurance Change

It is your responsibility to notify our office as soon as possible when you have any policy or insurance changes. Failure to do so will result in a denied claim; therefore, you are responsible for the balance due.

Patient Responsibility

If an insurance company has not settled a claim within 90 days, the patient will be notified and the responsibility for the balance will transfer to the patient. Our office will be happy to provide you with the information we received from the insurance company regarding non-payment of claim(s). Balances due over 120 days may be sent to an outside collection agency. Prompt payment is appreciated.

Disclosure / Agreement

I agree to pay for any and all medical services that my insurance company refuses to pay for, regardless of the reason. This office will file a claim on my behalf. If my insurance company denies payment for any reason, I will be responsible for the unpaid balance (non-covered expense, co-pays, co-insurance, and deductibles). Failure of the insurance company to pay within 90 days of filing is for the purpose of this agreement, a refusal to pay.

I understand that my insurance co-payment and any outstanding insurance deductible is due at the time services are rendered.

To change an appointment, please phone the office at any time. If the office is closed, voicemail is available. Except in cases of true emergencies, I agree to give 24-hour notice if unable to keep an appointment. **I understand that I will be billed a $50.00 missed appointment fee for appointments that I do not keep and for appointments canceled less than 24-hours before the scheduled time. I realize that these charges are not covered by insurance and I accept full responsibility for payment.**

In the event I do not pay for these or any other services rendered when due, I agree to pay any collection costs including, but not limited to, attorney fees and any related costs of collections should such action become necessary. All balances sent to a collection agency will automatically be charged an additional 35% of total bill due. You agree, in order for us to service our account or to collect any amounts you may owe, we and the collection agency may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and the collection agency may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I understand that I am responsible for all charges incurred during the course of my treatment, or other services not previously stated. I understand that after hours call, written consultations and telephone consultations of ten minutes or more will be charged.

I authorize Abundant Solutions, LLC release billing information which may include client name, date and type of services, diagnoses codes, substance abuse information and/or treatment plans to my insurance company/companies for the purpose of: collecting insurance benefits or for authorization of additional sessions for treatment by this office.

I have read the financial policy and disclosure agreement and I hereby authorize my benefits to be paid to this provider's office by my insurance company/companies realizing that I am responsible to pay non-covered services.

Patient's/Guardian's Signature_____ Date _____

Clinician Signature: _____ Date _____

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