

# Dipoto Counseling Group

## FINANCIAL POLICY

Thank you for choosing us as your mental health care provider. In order to reduce confusion and misunderstanding between our clients and this practice, we have adopted the following financial policy. We are dedicated to providing the best possible care and personal service to you and regard your complete understanding of our financial policies as essential element of your care and treatment. If you have any questions or concerns, please discuss them with your therapist. Please initial A - I and sign prior to receiving any treatment from our providers.

Upon arrival, please sign in at the front desk and notify us of any changes in your insurance or contact information.

**(A)** Please understand that payment of your bill is considered a part of your treatment. Insurance is a contract between you and your insurance company. **It is your responsibility to know and understand your insurance policy benefits.** We are not always a party to this contract. We will not become involved in disputes between you and your insurance regarding deductibles, copayments, covered charges, secondary insurance or other matters regarding reimbursement.

### **Insurance and Fee Policy**

**(B)** As a courtesy, we will verify, pre-certify and submit your insurance claim to a primary and secondary insurance plan. Your benefits, costs and co-payments as they pertain to your treatment will be discussed with you. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other insurance. Any amount that your insurance company will not be paying is due from you at the time services are rendered. We do not balance bill on insurance plans in which we are participating or contracted providers. You are responsible for providing this office with copies of your insurance card(s) or any changes with your insurance or coverage prior to being seen by one of our providers. Failure to do so may result in a denial of your claim making you financially responsible for your session(s).

**(C)** If you do not have insurance, full payment is due at the time-of-service. Unaccompanied minors will be denied service unless charges have been preauthorized to an approved credit card or payment is received at time of service.

**FULL PAYMENT IS DUE AT TIME OF SERVICE. IT IS NOT OUR POLICY TO BILL  
WE ACCEPT CASH, CHECK, OR ALL MAJOR CREDIT CARDS**

### **24-Hour Cancellation Policy**

**(D)** You will be charged for every scheduled appointment unless you cancel at least **24 hours** in advance. Late cancellation or no shows will be billed at the rate of \$50.00. Insurance carriers will not pay for no shows or cancellation charges, those will be your responsibility.

### **Appointment Reminder**

**(E)** We will make a courtesy reminder call 48 hours prior to your scheduled appointment. Ultimately, keeping scheduled appointments is your responsibility.

### **Credit Card Payment**

**(F)** You may choose to keep your credit card on file with this office to simplify the billing process and ensure that any fees are easily billed at the time of service. Payment is also accepted over the phone or on our website: [www.dipotocounselinggroup.com](http://www.dipotocounselinggroup.com)

### **Returned Checks**

**(G)** There is a fee of \$15.00 for any check returned unpaid by your bank. If your bank returns a check as unpaid, you will be placed on a cash or credit card only basis, as we will no longer accept checks from you.

### **Paperwork**

**(H)** There are times when you may need paperwork completed by one of our providers. There is a fee for filling out forms and reports. The fees vary according to the document(s) needed. Paperwork and forms can take up to 10 business days to be completed.

### **Divorce**

**(I)** If you have been or are now involved in divorce, please understand that, legally, we are not a part of the divorce and are not bound to any divorce decree issued by a court of law. The person that presents themselves or a minor child for treatment is responsible for payment of the medical bill. If your divorce decree states that your ex-spouse is to pay any portion of the medical bills, then you must pay us at the time of service and then seek payment from your ex-spouse per the terms of your divorce decree.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of patient



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## Treatment Contract and Patient's Rights

**Patient:** \_\_\_\_\_

I, \_\_\_\_\_, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at Dipoto Counseling Group hereby referred as the Practice. Further, I consent to have treatment provided by a psychologist, social worker, or counselor. The rights, risks and benefits associated with the treatment have been explained to me, as well as, alternative forms of treatment that are available. I understand that the therapy may be discontinued at any time by either party. The practice encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

**Recipient's Rights:** I certify that I have received the Patient's Rights notification and certify that I have read and understand its content.

**Non-Voluntary Discharge from Treatment:** A client may be terminated from the Practice non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the office, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the Group Director or request to re-apply for services at a later date.

**Client Notice of Confidentiality:** The confidentiality of patient records maintained by the Practice is protected by Federal and/or State law and regulations. Generally, the Practice may not say to a person outside the Practice that a patient receives services or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the Practice, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Practice's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not private health information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original.

I consent to treatment and agree to abide by the above stated policies and agreements with Dipoto Counseling Group.

\_\_\_\_\_  
**Signature of Client/Legal Guardian** **Date**  
(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

\_\_\_\_\_  
Clinician

\_\_\_\_\_  
Date