THE POLLOCK GROUP FINANCIAL POLICY

PLEASE READ THE ENTIRE DOCUMENT AND SIGN BELOW. YOUR SIGNATURE AND INITIALS ARE REQUIRED ON THIS FORM IN ORDER TO BE SEEN BY ANY OF OUR PROVIDERS.

- **All fees for services rendered by Clinicians associated with The Pollock Group are the responsibility of the client(s) receiving such services.**
- A health insurance policy is a contract between a **client and his/her insurance company**.
- As a courtesy, our office will file your claims to your insurance company. However, it remains **your responsibility** to:
    - assure that all charges incurred are paid in full, regardless of whether the insurance company pays or not.
    - verify with your insurance plan if your Therapist is a contracted provider and to understand and communicate your particular plan coverage benefits.
- Insurance 'coverage' is not a guarantee of 'payment'. Not all services are covered benefits in all insurance contracts.
- If your Therapist is **"in-network"** with your insurance plan, we are required by contract to collect your co-payment(s)/ co-insurance and any unmet deductible at the time of service. For clients with private insurance with whom his/her Therapist is **"out-of-network",** you will be required to pay for services at the time services are rendered, unless otherwise arranged with your Therapist.
- **Pre-authorization for services is the responsibility of the client.** Failure to fully inform your Therapist and our Office Manager about your plan requirements may result in your being billed for charges incurred.
- **Self-pay and non-covered benefit fees** are payable at the time of your appointment.
- Our Financial Policy requires that a credit or debit card be placed on file with our office prior to being seen by your Therapist. This allows us to provide ease of payment for you and your Therapist. Once your claims have been submitted to insurance, as applicable, and payments received (usually 15-30 days), you will be sent a Statement reflecting any balance remaining. **This balance will be charged to your credit/debit card on-file if we do not receive an alternate form of payment within 30 days of the date your Statement was sent to you.** Should your insurance company pay after you have already paid us, we will promptly refund any overpayment due to you.
- **Past due accounts** will be subject to further action (collection agency) if not paid in full within a 60-day time frame.
- Our office accepts cash, check, debit card, Visa, MasterCard, American Express and Discover cards.
- You will be held financially accountable for scheduled appointments missed without notification ("no show" appointments). You may also be held financially responsible for appointments canceled less than 24 hours in advance. These charges are not covered by insurance plans and will thus be your personal responsibility.
- Our Office Manager is available Monday through Friday (9:00am-3:00pm) to offer clarification or further information pertaining to the above policies. You are additionally encouraged to discuss any financial or billing difficulties with your Therapist as soon as they become apparent in order to prevent possible disruption to your therapeutic process.

Please read and initial the following specifics regarding our financial policy and payment processes.

_____(Initials) I understand I will be responsible for any remaining balance not covered by my commercial insurance company, Medicare and/or my supplemental policy, including any unmet deductible or co-insurance.

_____(Initials) I understand that it is my responsibility to know and understand what my specific insurance policy benefits cover and do not cover, and that if my insurance company fails to pay my Therapist or does not pay promptly, I will be responsible for the balance due.

_____(Initials) I understand that any outstanding balance on my account that is 60 or more days past due will be charged to my credit/debit card on-file with The Pollock Group, with an additional $25 charge incurred for any credit card 'denial'.

_____(Initials) I understand that delinquent accounts are referred to an outside Collection Agency. If my account is referred to a Collection Agency a 'collection fee' of up to 30% of my balance, plus an administrative fee of $25 will be assessed to my account.

_____(Initials) I further understand that I may not be able to reschedule appointments with my Therapist if my private pay balance is more than $300.

_____(Initials) I understand that a $25 'returned check fee' will be assessed to my account for any checks returned by my financial institution, and that payment of the original amount and fee will be due immediately and I will no longer be able to issue a check as payment to my Therapist.

I have read, understand and agree to meet my financial obligations in accordance with this policy.

_____	_____	_____
CLIENT/GUARDIAN PRINT NAME	CLIENT/GUARDIAN SIGNATURE	DATE

Credit/Debit Card 'ON FILE' Authorization

Revised 9/8/17

I authorize The Pollock Group and/or its representatives to retain my signature on file for the purpose of charging my credit/debit card account for any insurance co-payments, co-insurance, private pay balance due, and any other charges I personally incur that are not covered by insurance (e.g., no-show charges, testing, etc.) including any charges incurred by family members or others specifically listed below, per The Pollock Group Financial Policy.

OPTIONAL MONTHLY PAYMENTS:

I authorize The Pollock Group and/or its representatives to charge my credit/debit card listed below for monthly payments of $ _____ for _____ months from the date signed below.

Paying a balance due in monthly installments, as pre-arranged with your Therapist, will require a minimum of $100/month installments. Should you have questions concerning your bill or payment arrangements please contact our Office Manager and/or speak with your Therapist directly.

We take the security of your personal/financial information very seriously. Please be advised that your credit/debit card information is stored under lock and key and processed by our credit card merchant company who requires that our office complies with the strictest processing standards and security practices, monitored and attested to on an annual basis.

PLEASE SIGN: *I understand that, with the exception of any monthly payment arrangements indicated above, no charges will be made to my account outside the parameters described and attested to above.*

PLEASE CIRCLE THE CREDIT/DEBIT CARD TO BE PUT ON FILE

MasterCard **Visa** **Discover** **American Express**

_____ _____ _____
CREDIT CARD NUMBER **EXPIRATION DATE** **SECURITY CODE**

_____ _____
CARDHOLDER SIGNATURE AUTHORIZED FAMILY MEMBER

_____ _____
DATE AUTHORIZED FAMILY MEMBER