

**CONSENT TO BILL INSURANCE PLAN(S)**

* I give permission for Dr. Deb’s Center of Child & Family Development to bill my insurance company for covered services and to exchange information necessary to secure payment for these services. Such necessary information may include my (or my child’s) diagnosis, service dates, types of services and other information related to the Center’s services necessary to process claims.
* I will notify Dr. Deb’s Center for Child and Family Development of any changes to my (or my child’s) health insurance coverage, as well as any denial information.
* I understand that I am responsible for all member responsibility fees specific to my policy, such as copays, co-insurance, deductible balances, and any services that my insurance company does not remit payment for.

**FINANCIAL AGREEMENT & CANCELLATION POLICY:**

* Dr. Deb’s Center for Child & Family Development participates in a variety of insurance providers, BCBS and Multi-Plan. Fee for service, which may include assessment, consultation, training, technical assistance, designing individualized curriculum and progress monitoring systems, is billed at a per unit/contact hour OR per occurrence. Fees for services may range depending on the service that is requested.
* We will bill your insurance carrier for the services rendered with Dr. Deb’s Center for Child and Family Development. Authorization by your insurance company is not a guarantee of payment or coverage for services rendered. It is the responsibility of the client or client’s guarantor to render payment in full if your insurance company denies services**. Payment for the applicable copays, coinsurances or deductibles are due at the time of service.**
* If you need to cancel your appointment due to illness/injury or other circumstances, kindly give the earliest notice via phone and/or text message. We do understand that people get sick and ask that you do not attend your appointment within 24 hours of fever, and if the client is in a contagious state. Releasing your appointment time allows others to be served.
* A $150.00 charge will be billed for missed appointments. Clients will be discontinued from service after 3 no show appointments. A fee of $75.00 will be billed for late cancellations (less than 24-hours without a doctor’s note) and a fee of $25.00 per 15-minute increment (per CMS 8-minute rule) will be billed for late arrival/pickups.
* Clients may pay their account balances by personal check, money order, or credit card via our patient portal.
* A $50.00 returned fee will be issued if a personal check returns. If personal checks are returned more than one-time, personal check will no longer be accepted.

BY SIGNING BELOW, I AM AGREEING TO THE AUTHORIZATIONS, CONSENTS, AND RELEASES DESCRIBED IN THIS AGREEMENT. I HAVE READ THIS AGREEMENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

**DATE:**\_\_\_\_\_\_\_\_\_\_\_\_\_**PATIENT’S PRINTED NAME**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT’S SIGNATURE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_

IF THE SIGNATURE ABOVE IS NOT THE PATIENT’S, INDICATE BELOW THE RELATIONSHIP OF THE PERSON SIGNING FOR THE PATIENT.

**RELATIONSHIP:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PRINTED NAME**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(E.G., Parent, Guardian or Authorized Representative)