SANTA ROSA COUNSELING CENTER
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Licensed Marriage and Family Therapist
Licensed Mental Health Counselor
Brian E. Willis, M.S.
Registered Mental Health Counselor Intern
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Registered Mental Health Counselor Intern

PAYMENT POLICY

To help you understand and anticipate any difficulties in insurance benefits that you may encounter, please review this section thoroughly.

Thank you for choosing Santa Rosa Counseling Center, LLC for your counseling needs. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign/initial in the spaces provided. A copy will be provided to you upon request.

INSURANCE We participate in most insurance plans. If you are not insured by a plan we are contracted with or we are unable to verify your coverage, payment in full is required at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding coverage.

CO-PAYMENTS AND DEDUCTIBLES Co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

PROOF OF INSURANCE We must obtain a copy of your driver license and current valid proof of insurance. If you fail to provide us with correct insurance information in a timely manner, you may be responsible for the balance of a claim.

CLAIMS SUBMISSION We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility should your insurance company not pay your claim.** [initial _____]

COVERAGE CHANGES If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

NONPAYMENT If your insurance company has not paid your claim within 60 days, your balance will be billed and charged to you. If a balance remains unpaid, your account will be referred to a collection agency. Insufficient funds fee is $25.00.

MISSED APPOINTMENTS **You will be charged $75 for missed appointments and for appointments not canceled or rescheduled within 24 hours of the appointment.** These charges will be your responsibility and are billed directly to you. Please help us to serve you better by keeping your scheduled appointment. [initial _____]

PATIENT'S ATTESTATION

I fully understand the Payment Policy described above for Santa Rosa Counseling Center, LLC. **I understand that I am responsible for any balance not covered by or paid by my insurance company for any reason, to include billed amounts being applied to my deductible.**

Patient Name | Patient Signature | Date

CREDIT CARD AUTHORIZATION

Santa Rosa Counseling Center, LLC requires a credit card authorization be on file so that your balances can be settled as they occur. When credit card charges for unpaid balances arise, a statement of the charges and receipt will be mailed to you. [initial _____]

I authorize Santa Rosa Counseling Center, LLC to capture and securely store the below credit or debit card information and any additional payment devices I use for services with Santa Rosa Counseling Center, LLC and to use this information to collect outstanding balances on my/our account. I understand that when I provide a credit or debit card that does not have my name imprinted on it, by signing this policy or charge receipts I am acknowledging that I am an authorized user of that account. I understand that I may revoke authorization of a payment device in writing and that eligibility of services may be terminated unless a valid form of payment is on file.

Type of card: (Check one) ❑ Visa ❑ MasterCard ❑ Discover

Is this a debit card? ❑ Yes ❑ No

Credit Card Number | 3 digit CVV/CVC number* | Expiration Date (mm/yy) | Billing Zip Code

Name as it appears on card | Social Security Number | Driver License Number | State

Signature of Cardholder | Date

* This CVV/CVC number is printed on MasterCard & Visa cards in the signature area of the back of the card. It is the last 3 digits AFTER the credit card number in the signature area of the card.