Brandis Center, Inc.

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Financial Policy & Patient Responsibility

IT IS THE PATIENT'S RESPONSIBILITY:

- To know their insurance policy. Patients should be aware of their benefit coverage including which healthcare providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, coinsurance, and co- payments. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- To obtain a referral from their Primary Care Physicians (PCP) and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- To pay their co-payment at the time of the service.
- To promptly pay any patient responsibility indicated by their insurance carrier.
- To facilitate claims payment by contacting their insurance carrier when claims have not been paid.
- To notify our office immediately when your insurance plan or carrier has changed.

IT IS BRANDIS CENTER INC. RESPONSIBILITY:

- To provide quality therapy services.
- To file insurance claims as a courtesy to the patient. A 60-day period will be extended for pending insurance payment, after which the patient may be held responsible for the balance, as applicable by law.

CANCELLATION/NO-SHOW POLICY FOR SCHEDULED SESSION:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. We ask that you give us at least **24hr notice of a cancelation**. We ask that you make us aware of vacations or time away at least **30 days in advance**. Ideally, vacations or time away should be limited to no more than 5 business days. Frequent vacations/cancellations/no-shows can have an extreme impact on your child's treatment plan, as well as an impact on others who are waiting for treatment, and this may result in staff members being assigned to other patients and/or a pause in services.

SCHEDULED APPOINTMENTS:

We understand that delays can happen, however it is imperative that everyone arrives on time. If a client and/or family is 15 minutes past their scheduled time we will have to reschedule the appointment.

ACCOUNT BALANCES:

We will require that clients with self-pay, copay, or coinsurance balances pay their account balances to zero (0) prior to receiving further services by our practice. Clients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to our office personnel with whom they can review their account and concerns. Clients with balances over $100 must make payment arrangements prior to future appointments being made.

Initial: _____ Continue on next page:

NOTE: This **F**inancial Policy & Patient Responsibility expires one year after being signed.

ACKNOWLEDGEMENT:
I have read and understand the above financial policy. I understand that, regardless of my insurance claim status or absence of insurance coverage. I am ultimately responsible for the balance on my account for any services rendered, as applicable by law.

Printed name of Parent/Legal Guardian	Relationship	Date
Signature of Parent/Legal Guardian	Relationship	Date