Payment Agreement

1. Payment For Service. In order to effectively and efficiently serve our clients, Crystal A. McComas, LSCSW, LLC must keep our billing costs to a minimum, while helping you keep your costs for services affordable. Typically, like your physician, our office expects and receives payment at time of service. However, our office does offer payment plans in certain circumstances.

2. Insurance. If you would like to use your insurance benefits, Crystal A. McComas, LSCSW, LLC will submit a claim on your behalf to your insurance company. In order to submit the claim, Crystal A. McComas, LSCSW, LLC will need you to provide your insurance information and to authorize us to bill your insurance on this payment agreement form. It is your responsibility to call your insurance company (the number is typically on the back of your insurance card) to know your benefits and to get prior authorization, if needed. Some, but not all, insurance companies require a pre-authorization and will give you an authorization number to present to me at the first session. If this is required by your insurance, and you do not obtain the authorization number, you may incur charges that your insurance company will not pay. Therefore, you would be responsible to pay for those charges. Crystal A. McComas, LSCSW, LLC is a network provider with many insurance companies. Contact your insurance company to confirm that I am a network provider, or if the plan allows out-of-network benefits. You may also be required to meet a deductible. It is always a good idea to know your deductible because if you have not met your deductible you may pay more out of pocket expenses until that deductible is satisfied. Your insurance company can answer any questions you may have regarding your deductible. You are responsible for all costs not paid by your insurance including copayments, coinsurance, cancellation fees or any service not covered by your insurance.

3. Missed Appointment and Late Cancellation Fees. In order to serve current clients, and accept new clients, it is important that clients keep their scheduled appointments or give **AT LEAST 24 hours prior notice** if they must cancel an appointment. Crystal A. McComas, LSCSW, LLC will charge you a $50.00 fee for each and every missed appointment or late cancellation. A missed appointment is an appointment not cancelled, kept, or attended. A late cancellation is any appointment not cancelled with at least 24 hours prior notice. Crystal A. McComas, LSCSW, LLC may at its sole discretion waive any fees for missed appointments or late cancellations due to legitimate emergencies or other justifiable circumstances. **Please initial the line below.**

_____ I understand and agree that a missed appointment or late cancellation will result in me being charged $50.00 per occurrence. I understand and agree that repeated no-shows and/or unpaid no-show fees are grounds for termination of therapy.

4. Guarantors. If someone else is guaranteeing payment of you and/or your child's services, Crystal A. McComas, LSCSW, LLC must have their billing information and they must agree to one of these arrangements. Be aware that if the guarantor does not pay your bill, you will be ultimately responsible for its payment and possibly subject to collections. **Please initial below.**

_____ I understand and agree that I must pay all costs not paid by my insurance carrier. If I have another party (guarantor) paying my bill, I understand that I remain *primarily responsible*. This means that if that person does not pay outstanding charges, I remain liable for them.

5. Unpaid Balances and Returned Checks. If your and/or your child's account becomes past due, the account may be turned over to a collections agency or an attorney. If you move or relocate without making arrangements with Crystal A. McComas, LSCSW, LLC, for future billing, you may also be subject to immediate collection action. In addition, please be advised that if your check is returned, a $30.00 returned check fee will be added to your account.

6. Billing Options (Please Select and Initial One of the Following).

_____ **Health Insurance:** I am and/or my child is covered by a valid health insurance plan. I have contacted my insurance company for authorization (if necessary) and believe they will pay for these services. I agree to pay all costs not covered by insurance including refused claims, deductable, co-pay, missed appointment or late

cancellation fees, or coinsurance by one of the following methods. I have selected the following payment method for balances not covered by insurance **(you must also check one of the following):**

- ÿ **Authorization.** I hereby authorize Crystal A. McComas, LSCSW, LLC to communicate with and provide all necessary information to my insurance company in order to submit bills and to process my claims.

- ÿ **Payment in Full at Time of Service.** Unless otherwise agreed, I agree to pay all costs due when I attend and/or my child attends appointments including deductibles, copayments, and no-show fees. If I am not sure of my copayment, I will make a minimum payment of $20.00 until the actual amount is determined and will then make up any difference or receive a refund at my next appointment. **If I do not always accompany my child to his/her session I will send payment.**

- ÿ **Other: _____.**

_____ **Self-Pay:** I do not have or do not wish to use my insurance. I am paying all fees in full by cash, check or credit card at time of service. **(If you do not always accompany your child to his/her session you must send payment with your child.)**

_____ **Employment Assistance Plan ("EAP"):** I am a participant in an EAP and am requesting services from Crystal A. McComas, LSCSW, LLC under my EAP. I agree to cover all charges not paid through my EAP including charges incurred if my EAP refuses to pay for these services for any reason. If I continue with Crystal A. McComas, LSCSW, LLC, after exhausting my EAP services, I understand that additional charges will apply which may or may not be paid by my insurance company. I agree to pay any costs not paid by insurance as described in the next section.

Contact phone number for my EAP provider: _____. My Authorization # is: _____.

7. Divorced Parents. If you are a divorced parent who is not solely responsible for your child's medical and mental health care bills, by signing below, you are still agreeing to pay all charges incurred regardless of designations made by any court for division of medical expenses. If the other parent is a court-designated payer of mental health or medical services, that parent will be considered a guarantor and you will be responsible for obtaining a signed guarantor form authorizing payment. **Please initial below, if applicable**.

_____ I am a divorced parent who is not fully responsible for paying medical and mental health care bills of my child. I understand and agree that my child cannot continue to receive services from Crystal A. McComas, LSCSW, LLC, if I do not keep my child's account current, regardless of the other parent's attention to the account.

I hereby acknowledge that I have read the foregoing document or had it explained to me and my questions have been answered to my satisfaction. By signing this document, I hereby agree to pay for services from Crystal A. McComas, LSCSW, LLC, under the terms and conditions set forth herein.

_____ _____

Signature Date Printed Name

_____ _____

Relationship to Client/Authority Signature of Staff Witness Date