Psychological & Counseling Associates

Dr. Belvia W. Matthews & Dr. Calvin O. Matthews

PATIENT/RESPONSIBLE PARTY FINANCIAL AGREEMENT
PLEASE TAKE A MOMENT TO READ CAREFULLY

Welcome!

In order to make your transition as simple as possible, below are some policies that you will need to read and sign. Our office staff looks forward to serving you as a client.

1. All patients will need to bring the following items: **A CURRENT DRIVER'S LICENSE/PICTURE ID AND AN UPDATED INSURANCE CARD**. If you do not have proof of insurance, you will be expected to pay if full at the time of service. There will be an interest rate of 1.5% on accounts over 60 days past due. This charge will only be billed for the patient balance. Signature _____

2. **Office hours are 8:00 a.m. to 5:00 p.m. Monday thru Thursday and 8:00 a.m. to 12:00 noon on Friday. The office is closed from 12:00 p.m. to 1:00 p.m. daily for lunch.**

3. In the event of an emergency, please contact the office. During office hours, our staff will assist you with any questions or concerns you may have. After hours, please contact your nearest emergency room or dial the crisis line at 256-716-1000. Signature _____

4. You expect good quality service and the fees charged are comparable to those charged in our community for professional counseling services. The initial diagnostic session is $170.00 and the following sessions are $165.00. **All co-payments and fees are due at the time of service. We accept Cash/Check/Credit or Debit cards.** Signature _____

5. **I am aware that I will be charged a $100.00 fee for Dr. Belvia Matthews and a $50.00 fee for Dr. Calvin Matthews for canceling an appointment without a 24 hour advanced notice or if I do not show up for my appointment. I am aware this fee is not billable to insurance and that I am responsible for the entire fee.** Signature _____

6. I am aware that if I have repeat cancellations and/or No Shows that my therapist has the right to terminate services due to non-compliance with treatment and care. Signature _____

7. I understand that I am financially responsible for all charges whether or not paid by my insurance. If my check should be returned due to insufficient funds, I am responsible for a returned check fee of **$38.00 plus the amount of the original check.** Signature _____

8. Should collection proceedings become necessary, I accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees (33.33%), attorney fees and/or court costs, if such be necessary.
   Signature _____

9. You agree, in order for us to service your account or to collect monies you may owe, Psychological & Counseling Associates, P.C. and/or our agents may contact you by phone at any phone number associated with your account, including wireless phone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I/We have read this disclosure and agree that Psychological & Counseling Associates, P.C., its employees and/or agents may contact me/us as described above. Signature _____

10. I am aware all co-payments are due at the time of service.
    Signature _____

11. I am aware that authorization from my insurance company **does not** guarantee payment. I am aware that only a portion is paid by my insurance company for any assessment/evaluation/testing/psychotherapy and the balance is my responsibility. I hereby authorize the Doctors to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions. Blue Cross/Blue Shield patients, please check specifically with your insurance company's payment schedule for psychotherapy/psychological assessment & evaluation as they do not provide preauthorization for testing, and in many cases, psychotherapy. **Please know the benefits of your insurance plan. If you have a deductible which has not been met, or your insurance deems your visit as a non-covered service, you are responsible for the balance. The terms of your insurance plan are between YOU and YOUR insurance company. WE DO NOT DETERMINE YOUR BENEFITS OR PAYMENT TERMS.**
    Signature _____

12. If the Doctor has to appear in Court either by subpoena or by patient request, the fee is $800.00 with a $400.00 deposit. The full court appearance fee is required within 3 days prior to the court date. Signature _____

I have read and understand the above. If the patient is a minor, this is to be read and signed by the parent/guardian.

_____ _____
Signature of Insured/Responsible Party Date

_____ _____
Witness Signature Date