**Patient Financial Responsibility Policy**

Thank you for choosing Chaperone Counseling Services as your mental health provider. We are committed to building a successful therapist-patient relationship. Your clear understanding of our Patient Financial Policy is important to establishing a partnership with you. By signing and initialing below you acknowledge and agree:

\_\_\_\_\_\_\_ 1. I am informed that Chaperone Counseling is an out of network provider for my insurance carrier. I understand that my insurance carrier will process claims in accordance with my out-of-network benefits and subject to co-insurance, deductible and in some instances co-pay.

\_\_\_\_\_\_\_ 2. I, the patient acknowledge, understand and agree that payment is due from me at the time services are rendered. I further understand that CCS is providing mental health services to me in consideration of expected provider reimbursement.

\_\_\_\_\_\_\_ 3. I understand that my insurance company may send provider reimbursement checks directly to the subscriber and that the subscriber may be a family member other than me. I agree to inform and share this financial policy with the subscriber of my insurance policy.

\_\_\_\_\_\_\_ 4. I understand and agree that it is my responsibility to ensure that the subscriber endorses the back of the check and to see that the check and accompanying explanation of benefits is remitted to CCS within 5 business days of receipt to: 3415 S. Sepulveda Blvd. Suite 1145 Los Angeles, CA 90034

\_\_\_\_\_\_\_ 5. I understand that should the subscriber deposit the insurance check, I remain responsible for remittance of the provider reimbursement to CCS, within 5 days of deposit, via cashier’s check, credit card payment, check or money order. Furthermore, unless I am a minor, I am responsible for all charges assessed by CCS.

\_\_\_\_\_\_\_ 6. Insurance Benefits: I understand that my insurance policy is a contract between myself and my insurance company. CCS will submit your claim to your insurance carrier as a courtesy to you where applicable. I agree to facilitate payment of my claims by contacting my insurance carrier when necessary. I understand that I am directly responsible to CCS for all bills submitted by it for services rendered to me, including any coinsurance, deductibles and co-payments as determined by my insurance carrier.

\_\_\_\_\_\_\_ 7. I understand that if the insurance check is sent directly to CCS, that CCS will credit my account for future sessions and/or deduct from balances owed for services.

\_\_\_\_\_\_\_ 8. Non-Payment on Account: I have been informed and understand that failure to remit payment in full to Chaperone Counseling Services within 5 days of receipt of any insurance checks (Provider reimbursements) may result in a delinquent account status. Should collection proceedings or other legal action become necessary to collect on a delinquent account, I understand that Chaperone Counseling has the right disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. I have been informed that I am responsible for all costs of collection which may include but is not limited to: (a) 25% collection fee, (b) all court costs and fees to the extent allowed by law, (c) reasonable attorney fees and (d) interest added to my balance at the legal rate prior to any litigation or as a result of assignment to a collection agency. I further understand that any interest assess is as a result of delinquency on my account and is not deemed interest as part of a credit transaction.

Assignment of insurance benefits, The undersigned authorizes direct payment to the providers of any insurance benefits otherwise payable to the undersigned for mental health services at a rate not to exceed the provider’s regular charges. It is agreed that payment to the providers, pursuant of this authorization, by an insurance company discharges the insurance company of any and all obligations under a policy to the extent of that payment. It is understood by the undersigned that he or she is financially responsible for charges not covered by this assignment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient/Subscriber Signature Date