Chrysalis
Center for Counseling
and Eating Disorder Treatment

OFFICE PROCEDURES AND FINANCIAL AGREEMENT

Please read, initial, and sign below. You may request a copy for your records.

Chrysalis is a business office where a number of mental health professionals practice. Your contract for services is with our office and applies to any and all providers you may see here.

APPOINTMENTS:
All office visits are by appointment and may be scheduled through our administrative staff. Please arrive on time, as you cut down on your appointment time when you arrive late. The usual length of an appointment is 45-50 minutes. If you arrive more than 15 minutes late, you may be asked to reschedule your appointment, which will result in a *late cancellation* charge.

Payment: Payment is required at the time services are rendered, whether you are a self-pay client or have insurance coverage. Acceptable methods of payment include cash, check, VISA or Master Card. *The fee for returned checks is $35. If a second check is returned, you will be asked to arrange another method of payment.*

Late cancellations/No shows: For a missed or late cancelled clinical or nutritional appointment, you will be charged up to $60 for the appointment (unless otherwise specified by your insurance carrier). Please note: both clinical and nutritional appointments must be cancelled by 9:00am the business day before. Please be advised that reminder calls are a courtesy, and you will be billed for late cancellations and no-shows regardless of whether or not you received the reminder message. Repeated late cancellations and/or no-shows may result in dismissal from treatment, at our discretion.

INSURANCE:
As a courtesy to you, we will bill rendered services to your insurance carrier. We do not accept Medicaid. Insurance co-payments, coinsurances, and deductible payments are due at the time of service. However, verification of eligibility and/or benefit information is not a guarantee of payment by your insurer. Your benefits will be determined once a claim is processed by your insurer, which will be based upon your eligibility and the terms of your certificate of coverage applicable on the date services were rendered. In the event of non-payment from your carrier, you are responsible for payment to Chrysalis for services rendered and you will be responsible for handling any disputes with your insurance carrier. *It is your responsibility to be aware of your insurance benefits and needs for pre-authorization. Any services not covered by your insurance are your responsibility.*

Please note: treatment information including diagnosis, type of treatment, costs of service, dates of service, and providers, may be shared with your insurance carrier for reimbursement purposes. Please be aware that any information communicated to your carrier may affect your benefits. If you decide to file through insurance, we reserve the right to share this information with your carrier upon their request.

OUTSTANDING BALANCE:
You are responsible for paying any outstanding balances due on your account. Once we receive an Explanation of Benefits from your insurance carrier, your balance may be adjusted based on your carrier's allowed amount. If an account accrues two or more unpaid sessions, ongoing services may be immediately postponed until full remittance is received. Please be advised that if Chrysalis does not receive payment in full for services rendered, your treatment may be discontinued.

If you are unable to pay your balance in full, a signed *payment plan agreement* will be implemented immediately. Failure to adhere to your payment plan is grounds for discontinuation of services. If you previously discontinued your care or were discharged from treatment, and you desire to resume receiving services at Chrysalis, you will be expected to remit any unpaid balance prior to being seen. Payment plans may be arranged with the Office Manager or Accounts Receivable Manager. Any balance not paid in 90 days will be subject to collections.

Late Fees: A late fee of $25 will be charged to delinquent accounts that are not paid within 90 days of the issue date of the first bill and will also be referred to a third party collection agency. You will continue to be responsible for all associated collections and fees.

ADDITIONAL SERVICES
In some circumstances, depending on the time involved and nature of task, you may be charged for additional services, such as extended sessions, scoring psychological testing, preparing a psychological report, writing letters of advocacy or documentation on your behalf, extensive clinical coordination, and extended consultations with other providers regarding your treatment.

Testing Fees: Charges for psychological testing apply to all tests taken and scored. Sometimes, insurance companies do not reimburse for testing. In this event, you will be responsible for uncovered testing costs at our self-pay rate.

Conjoint Sessions (with more than one therapist): Conjoint sessions will be billed according to your benefits, which may result in a self-pay rate.

Additional Services: Extensive services that involve clinical coordination and continuity of care may constitute an additional fee that is separate of therapeutic services. Phone calls that are extended and/or that constitute therapy may require an additional fee. These additional services will be charged up to $90/hour.

Changes to the Policy: Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime and are available on our website.

Please initial at each line and sign below to indicate that you have read, understood, and agree to the above policies. For minors, parent/guardian must sign.

_____ I have read, understand, and agree to the above policies.

_____ I have discussed these policies and addressed concerns and questions with the Office Manager or AR Manager.

_____ I have been offered a copy of these policies to take with me if I desire.

_____ I authorize Chrysalis to release any information acquired in the course of my therapy to my insurance company as needed.

_____ I understand my insurance coverage is a relationship between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred.

Signature of Client	Date
Signature of parent or Legal Guardian	Date
Signature of Office or AR Manager	Date