LINDA DIVINE, LSCSW, LLC

FINANCIAL POLICY

Thank you for choosing me as one of your health care providers. I am committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of the Financial Policy which requires that you read and sign prior to any treatment.

Fee for Service

Initial intake sessions are $150. The fee for follow-up sessions is $140.00. It is the patient's responsibility to check insurance benefits. Insurance deductibles and co-payments are due at the time of service. If you do not plan to use insurance, full payment is due at the time of service. The charge is $120.00 per hour for report writing, preparation of records, treatment summaries, therapy on the telephone, or any other service provided at your request--these services are not covered by your insurance.

Regarding Insurance

Full payment is expected at the time of service if you have not yet met your deductible for the year. I may accept assignment of insurance benefits; however, I require co-payment for each visit to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. I cannot bill your insurance unless you bring in all insurance information. Your insurance policy is a contract between you and your insurance company. I am not a party to that contract. If your insurance company has not paid your account in full within 90 days, the balance of your account will be automatically billed to you. I will be glad to provide the necessary information to you so you can pursue payment from your insurance company. Please be aware some and perhaps all of the services provided may be "non-covered" services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. If you are a beneficiary of Medicare or eligible for Medicare, please indicate so even if you do not plan to use it.

Missed Appointments and Timely Payment

Unless canceled at least 24 business hours in advance, the policy is to charge for missed appointments at the rate of a normal office visit. Please help me serve you better by keeping scheduled appointments. If you do not pay your bill in a timely manner, your account will be turned over for collection and you will be assessed a 25 percent fee in addition to the balance due.

I understand and agree to the "Missed Appointment and Collection Policy". _____
Initials

Confidentiality

Many insurance companies request information about you including a diagnosis. Please be advised that I lose control of that information once it leaves this office and cannot promise confidentiality by the insurance company. Some people choose to self-pay as a way to protect their confidentiality and that option is agreeable with me should you choose to utilize it.

Thank you for understanding the Financial Policy. Let me know if you have any questions or concerns.

I have read the Financial Policy (above). I understand and agree to this Financial Policy.

X_____ _____
Signature Patient or Responsible Party Date

X_____ _____
Signature Co-Responsible Party & Relationship to Patient Date

1/14/2020