Rebecca Abbott Kelley, LCSW

Financial Policy

Thank you for choosing me as your mental health provider. 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 my financial policy which I require that you read and sign prior to treatment.

Before treatment you must complete information forms. Payment is due at the time of service. I accept cash or checks.

Insurance:

Payment is required at the time of your visit. For clients who have medical insurance I will file that insurance provided I accept their insurance.If you have a medical spending account and need to file a claim with them, I will provide you with a statement receipt. If I am not a contract provider with your carrier, you are responsible for full payment. If you have a deductible, you are responsible for paying each visit in full until you have met that obligation with the carrier. You are also responsible for keeping me updated with your current insurance information.

Missed Appointments:

Unless cancelled at least 24 hours in advance (a business day), my policy is to charge the normal office visit rate. Your insurance company will not cover this expense so it will be your responsibility to pay. If is your responsibility to remember you appointment day and time.

Please let me know if you have any questions or concerns. I have read the policy and agree to the terms.

_____ _____

SIGNATURE OF CLIENT OR RESPONSIBLE PARTY **DATE**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SEE COPY IN OFFICE LOBBY

I, _____, have read or received a copy of this office's Notice of Privacy Practices.

_____
Print you name

_____
Signature

_____
Date

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