Coastal Counseling Center, PC

809 Kent Pl Chesapeake, Virginia 23320

757-436-0605 (Voice) 757-436-0023 (Fax)

INDEPENDENT CONTRACTOR AFFILIATES FINANCIAL AGREEMENT & PERMISSION FOR TREATMENT

BILLING STATEMENTS WILL BE SENT VIA EMAIL, sent from "InSync Administrator".

We Accept: **Cash, Credit Cards, or Personal Checks**

Service	Fee
Initial Assessment by Therapist	$130
Follow-up Therapy Sessions (Length Dependent)	$100 -$125
Initial Assessment by Medication Provider	$200
Follow-up Medication Management Services	$100
FEES **NOT** COVERED BY INSURANCE	
INSUFFICIENT FUNDS FEE	$40
COPIES OF MEDICAL RECORDS (paper or electronic)	$20 + .50/page up to 50 pages, then .25/page
LATE CANCELLATION (Cancellation less than 24hrs prior to scheduled appointment time.)	$50
NO SHOW (Missing scheduled appointment without calling to notify provider.)	$80
MEDICATION REFILL/FORMS/DOCUMENT/PHONE CALL	$25.00 - $100.00
COURT APPEARANCE FEES	$750.00 min (billed in 3hr increments)
DELINQUENT ACCOUNTS	1.5% per month (18% per annum) plus court costs & attorney fees

PAYMENT IS REQUIRED AT THE TIME OF SERVICE: Coastal Counseling Center, PC (CCC) will collect insurance co-payments at the time of service. The copayment is only the estimated amount not paid by the insurance and includes unpaid deductibles. CCC will then file primary insurance claims one time on behalf of the patient for services rendered by either an employee or independent contractor affiliate. Any outstanding balance that is not paid by the insurance due to denied claims or lack of coverage will be billed to the responsible party. Any remaining unpaid balance will be charged to the card on file. CCC may prevent scheduling future appointments until outstanding balances are paid.

RESPONSIBLE PARTY: The patient is considered the **responsible party** unless there is a parent or other legal guardian legally responsible for the patient. The responsible party, not the insurance company, is ultimately liable for payment at the time services are rendered.

NO SHOWS AND LATE CANCELLATION: Missed appointments and last-minute cancellations affect the schedule of the clinicians and take appointments from others in need. To avoid a late cancelation fee, cancellations must be made during regular business hours at least 24 hours prior to your scheduled appointment time. Please call to discuss with staff or leave a voicemail as soon as you realize you are unable to attend.

MEDICATION REFILL/FORMS/DOCUMENT/PHONE CALL FEES: The patient will be billed for the provider's time should the patient request medication refills outside of scheduled appointments or if the provider is requested to speak, meet, or correspond in any way with another person to include but not limited to an attorney, probation officer, CPS worker, physician, etc. The charge for documents must be paid in advance.

COURT APPEARANCE FEES: This fee applies when a provider or any staff is subpoenaed to testify and is payable in advance, regardless of whether we actually testify or appear in court. If we are required to be on call beyond the three hours for court appearances, an additional $750.00 minimum fee will be incurred even if we must remain on call for one minute, one hour, or all three hours whether we testify or not.

Initial _____

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DELINQUENT ACCOUNTS: The credit card on file will be charged for the full amount of any balance unpaid for more than 30 days. Collection procedures will be initiated for all unpaid balances greater than 60 days past due. Your signature below certifies that you agree to waive all homestead deed exemption rights and pay court cost of all collections including actual attorney fees.

STATEMENTS AND CHANGES: Coastal Counseling Center, PC employs a third-party vendor, EasyPay, to securely maintain a credit card on file. This is done for ease of payment but, we also accept cash and checks. Fees are subject to change and you will be given at least 30 days of notice of any changes. Account statements are available upon request.

I attest that I understand and agree to the above provisions and conditions of the Independent Contractor Affiliates Financial Agreement & Permission for Treatment, and I hereby authorize Coastal Counseling Center, P.C. and/or my provider (Independent Contractor associated with CCC), to provide counseling, psychotherapy, and/or medical treatment, for myself or my child by those duly licensed in the Commonwealth of Virginia. I agree that CCC and/or my provider may release information pertaining to treatment to my insurance and authorize my insurance company to pay my benefits directly to CCC for services rendered.

Patient: ________________________________ Responsible Party: ______________________ Date: ______________

Credit Card Authorization

This is necessary so we have a backup for any missed session fees, forgotten payments, etc. even if you do not intend to use a credit card for payment.

By signing this agreement, I am authorizing Coastal Counseling Center, PC to bill my credit card for professional services rendered to (patient name) ______________________________. I agree that I will not dispute valid charges, which may include:

- Agreed upon fees for services as listed in the ***Independent Contractor Affiliates Financial Agreement & Permission For Treatment***
- A missed appointment fee if the client does not show up for a scheduled appointment or cancels with less than 24 hours' notice
- Denied/Hold or Insufficient Funds will incur the check amount and a $40 fee
- Co-pays, cost-shares, deductibles, or any fee not covered by your insurance

Unpaid balances will be charged to the card on file after 30 days. Credit Card transactions that are declined due to a Hold or Insufficient Funds may be subject to Insufficient Funds Fee.

CARDHOLDER INFORMATION**:** Name: ____________________ Relationship to client: ________________

Billing Street Address: _______________________________________ City: _________________ State: _____

Postal Code: ______________ Email: __________________________ Telephone: _________________

CREDIT CARD INFORMATION: □ MasterCard □ Visa □ Discover Card □ AMEX—□ HSA or HRA card
Last 4 digits: ________________Expiration Month/Year: ____/_____

Cardholder Signature _______________________ Date _____________

Complete if cardholder is NOT the client.

I, (client name)____________________________, authorize Coastal Counseling Center, PC to disclose billing information to the above named cardholder.

Client signature _____________________________________ Date ______________

Initial _____