363 W. Big Beaver Rd. Ste 400
Troy, Michigan 48084

Nexus Behavioral Health PLLC

Telephone: 248-509-7657
Fax: 248-509-7658

FINANCIAL POLICY

We are pleased that you have chosen our office to provide for mental healthcare needs. For your benefit, we accept different insurances. As a condition of your treatment by our office, financial arrangements must be made in advance.

Patients who carry insurance understand that services rendered are charged directly to the patient and that he/she is personally responsible for payment for all services. Most insurance companies reimburse a percentage of the costs of our services. It is important for you to understand your insurance policy and what benefits are available to you. Our billing department will automatically file your claim, but if you are required to submit information to them prior to payment, this is your responsibility. If you are not using insurance, payment in full is expected at the time of your appointment.

In consideration for the mental healthcare services rendered to me, any member of my family, or any other person at my request, I agree to pay for all services rendered at the rates indicated in the table below. I understand that I am financially responsible for all outstanding charges whether or not paid by the insurance company. At the discretion of this office, a payment plan may be made available for your outstanding charges. All payment plans will be made in writing and require the execution of a separate document. No oral agreements for payment have or will be made.

Service	Rate
Initial Assessment	$200.00
Individual/Family Therapy	$180.00/hr
Psychological Testing	$200.00/hr
Legal/Court Fees	$250.00/hr
IEP/School Advocacy	$100.00/hr
Disability/FMLA Paperwork	$150.00

Services provided outside of regularly scheduled visits (i.e., Depositions, IEP meetings) may be charged at an additional rate. In general, additional fees are based on the amount of time a clinician needs to spend on your request. Your insurance reimburses for your therapeutic treatment only. For example, it does not cover time spent interfacing with school personnel, drafting letters, completing disability claim forms, etc. At the discretion of your practitioner you may be billed for these services and will be informed in advance of these charges. You have the right to rescind your request for these services if you so choose.

When using health insurance, I am aware that there may be certain requirements based on the contract held with said insurance company. These requirements may come in the form of a copay, coinsurance amount, or deductible. I acknowledge that I am responsible for the financial amount owed noted by my insurance company (e.g., sometime identified as “Patient Amount”) and also acknowledge that pursuant to rules and ethical statutes set forth by my insurance company and the State of Michigan, that amount is due the day services are rendered. I also acknowledge that if telehealth services are being rendered, a form of payment is requested to be kept on file (i.e., credit card, HSA card, etc.) and the amount owed will be charged to the payment source on file at the time the amount owed is generated (i.e., day of session, receipt of ERA, etc.). As a courtesy, Nexus Behavioral Health will inform me of any payment amount exceeding $200 prior to charging the payment source. Itemized billing or receipts will be made available upon request. If a payment plan has been agreed upon between Nexus Behavioral Health, the

clinician providing services, and myself, it will be the agreed upon amount charged to my source of payment.

I acknowledge that if my balance owed exceeds $300.00 with no attempts made to make payments towards the balance, at the discretion of my clinician, services may be paused as not to continue accruing a larger balance. In cases where assistance may be needed due to financial hardship, I acknowledge that I may request a payment plan or other financial assistance.

Missed therapy appointments will be charged at a rate of $100.00 if they are not cancelled at least 24 hours in advance. For testing appointments that are not cancelled within 48-hours notice, a $300.00 fee may be charged. Insurance companies do not reimburse this fee and you will be held 100% responsible for the missed appointment fee. Waiver of missed appointment fees occurs only at the discretion of the clinician you are seeing and our billing staff are unable to help with this issue.

In case of divorced or separated parents, we are aware that often the non-custodial parent is responsible for payment of medical bills, including mental healthcare. However, if the legally responsible party does not respond to our requests for payment, the responsibility for the payment falls to the parent who arranged for our services.

I understand that there will be an additional $30.00 service charge on all returned checks. I understand that after one returned check, the only acceptable method of payment is cash or credit card.

I grant my permission to your office to contact me at my home, my place of business, or via my cell phone to discuss matters related to this form. I also agree to let this office leave messages concerning this form on my answering machine(s).

I authorize release of all identifiable information concerning my account, including charges billed, payments made, and interest charges, etc. to your office and any collection agency this practice decides to use. I authorize release of information to insurance carriers to collect on my behalf. I authorize payment to come directly to your office.

This agreement supersedes all prior agreements signed, including any and all mediation or arbitration agreements. I acknowledge that any prior mediation or arbitration agreements signed previously related to financial arrangements are null and void. I acknowledge that I have received a copy of this office's Privacy Policy (HIPAA agreement) and I hereby agree to abide by the conditions outlined herein.

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Signature of Patient, Parent, or Guardian Date