363 W. Big Beaver Rd. Ste 200
Troy, Michigan 48083

Nexus Behavioral Health PLLC

Telephone: 248-509-7657
Fax: 248-509-7658
E-mail: Admin@nexusbehavioral.com

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. While insurance benefits may be checked as a courtesy, it is important for you to understand your insurance policy and what benefits are available to you. In the event that your insurance company declines to pay for care, you as the client are responsible for any charges related to services provided by Nexus Behavioral Health PLLC. 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.

Any questions regarding billing should be directed to Nexus Behavioral Health.

In consideration for the mental healthcare services rendered to you, any member of your family, or any other person at your request, you agree to pay for all services rendered at the rates indicated in the table below. You understand that you are 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 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.

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, including preparation time. 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.

Missed appointments will be charged at a rate of $100.00 if they are not cancelled at least 24 hours in advance. A 24-hour notice gives us a chance to allow another patient to use that time, as appointment time is limited. 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. Arrival more than 10 minutes late for a scheduled appointment may result in the appointment being canceled. If two consecutive recurring appointments are missed or canceled, the recurring appointment may be removed from the schedule at the discretion of the clinician.

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.

There will be an additional $30.00 service charge on all returned checks. After one returned check, the only acceptable method of payment is cash or credit card.

It is understood that the charges shown by invoices or statements are due and payable in full at the time of services. A service charge of 1.75% (21% per annum) of the unpaid balance will be assessed on all accounts exceeding sixty (60) days past due. Clients with large outstanding balances will have their accounts reviewed and may not be eligible for further services unless previous written arrangements are satisfied. If accounts are not paid in a reasonable time, collection services will be utilized. I agree to pay court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee up to 40% of the outstanding balance as compensation to this office for any commission it must pay to a collection agency in collecting any outstanding balance.

By signing, I am verifying that I have read this statement in its entirety, and that I agree to this statement. 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, billing company, 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. 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. By signing, I am acknowledging that I have the right to refuse or terminate services at any time.

_____ _____

Signature of Patient, Parent, or Guardian Date