Jennifer Lancaster, PMHNP-BC
Krystle Mills, PMHNP-BC

Empowering Minds Behavioral Health PLLC Agreement of Financial Responsibility

Thank you for choosing us as your mental health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

• Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept credit cards, ACH payment, and pre-approved insurance for which we are a contracted provider.

• It is our policy to have a credit card or ACH payment on file prior to your appointments. We will charge the co-payment prior to your appointment. After the visit, when charges sent to the patient's insurance are responded to, any remaining balance will then be billed to the credit card on file. In addition, late cancellations (within 48 hours) or no- show fees and any forms or letters requested to be filled out by a provider will be charged to the credit card.

• It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.

• We will attempt to confirm your insurance coverage prior to your treatment. However, it is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.

• If we have a contract with your insurance company, we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

• If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for possible reimbursement.

• Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

• Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments, and limited annual benefits. If you receive services that are part of an Out-of- Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

**I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

**Once I have signed this agreement, I agree to all of the terms and conditions contained herein and the agreement shall be in effect from this date forward.

Patient Printed Name _____

Responsible Party Printed Name _____

Responsible Party Signature _____

Signature Date _____