Behavioral Healthcare of Fredericksburg Fee and Billing Policies

Patient's Name: _____ Date of Birth_____

We expect payment at the time of each visit. If you are insured by one of the companies with whom we have a participation agreement, you will be responsible for paying your co-payment and any deductible amount.

Your appointment is a time that is reserved for your use. We do not double schedule and generally run within 10 minutes of appointment times. You will be billed a $50 fee for any missed appointment that is not cancelled at least 48 hours in advance. Health insurance will not pay for missed appointments.

If a payment made by check does not clear your checking account, a $25 administrative fee will be added to your account balance. In addition, we may require cash payment for all future services.

Should your account become delinquent, we may refer your account to a collection agency or seek the assistance of the General District Court. A fee, equal to 33% of the outstanding balance, will be added to your account if such action is necessary. You will also be responsible for any legal fees associated with collection activities.

Choose one of the following billing options by initialing on the blank:

_____I would like you to bill my health insurance. I assign payment of benefits to you and will be responsible for the co-payment and any deductible amounts at the time of service. If, for any reason, my insurer does not pay for the charges associated with the services, I will be responsible for the remaining balance.

_____I will make full payment at the time of services. I do not authorize billing of my insurance. Intake rate $130.00; 50-minute session $100.00; 25-minute session $50.00. Sliding fee scale available upon request.

Insurance Benefit Authorization

I hereby authorize Behavioral Healthcare of Fredericksburg (BHF) to apply for benefits on my behalf for covered professional services. My signature authorizes that payment be made directly to BHF. I further understand that I am financially responsible to BHF for charges not covered or reimbursed by my policy up to the fee that BHF has agreed to accept. I certify that the information I have reported, with regard to my health insurance coverage, is correct and further authorize the release of any necessary information, for this or any related claim. I permit a copy of this authorization to be used in place of the original.

In the case of Medicare or Medicaid, I request that payment of authorized benefits be made to BHF on my behalf. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services.

I as patient or responsible party have read and agree to all on this page.

Signature: _____ Date: _____

Patient or Responsible Party