Mary Byrd LMHP

*1710 North 144th St. * Omaha, NE. * 68114*
*phone: 402.651.4673 * fax: 402.614.6174*

Office Financial Policy and Billing Agreement

Name (*print)*:_____Soc.Sec._____

Insurance Coverage:

- Client agrees to contact **Insurance Company to verify Mental Health benefits. You pay for your insurance. It is your responsibility to know the benefits of your policy. _____** (Initial)
- Should a dispute arise on a claim, **it is generally the clients' responsibility to clarify and resolve the dispute with the insurance company. _____** (initial)
- If insurance *is* being filed, any deductible not yet met is **due at the time of service as well as any co-pay.** _____ (initial)

Payment:

- If Insurance *is not* being filed, **payment is expected at the time of service. _____** (initial)
- **I agree to provide a 24 hour notice to cancel an appointment.** _____(initial)
- **If a client does not show for a scheduled appointment, there is a no-show charge of $50.00. Medicaid clients will be charged $10.00. _____** (initial)
- A service requested by the client, but not covered by the client's Insurance Plan, may be arranged under a separate written agreement with the office. _____ (initial)
- Phone calls are **not** billable to your insurance. Phone calls are **billed for the amount of time spent on the phone, at the pro-rated hourly rate**. (See fee schedule). _____ (initial)
- Fees are subject to change at the discretion of the practice. A fee schedule in available upon request. _____ (initial)
- There is a $20 administration charge for checks that do not clear the bank. _____(initial)
- Questions regarding your account should be directed to the Billing Office at 398-1138. _____ (initial)

I certify that I have read, understand and agree to the foregoing. The undersigned is the client or is duly authorized by or on behalf of the client to execute the above and accept its terms.

_____ _____
Signature of Client or Responsible Party **Date**

_____ _____
Signature of Witness **Date**