McArthur Counseling Center Insurance Policies 2016

Full payment is due at time of service

We accept Cash, Checks, Visa, MasterCard and Discover

FINANCIAL POLICY

We do not carry outstanding balances for co-pays and deductibles, unless prior arrangements have been made. **Accounts with balances more than 60 days old will be subject to review and possible delays in treatment until balance is paid in full. A late fee will be charged for all balances that are more than 90 days**. Please help us keep our costs down by keeping your account current.

DELINGQUENT ACCOUNTS WILL BE SUBJECT TO COLLECTION/COURT ACTION OR TERMINATION/SUSPENTION OF SERVICE.

Parents bringing in a minor child; The parent that brings the child is responsible for any and all payments/charges regardless of any court order or decree.

INSURANCE POLICY

We may accept assignment of insurance benefits after your first visit. However, we do require any deductibles and / or co-pays to be paid at the time of service. **The balance is your responsibility whether your insurance carrier pays or not.** Your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract. Check with your insurance for your exact benefits.

Our charges have been established based upon current (insurance approved) reasonable and customary rates for our area. Should your insurance company be unable to meet current standard payment scales, you will be responsible for the difference.

We will file your insurance as a courtesy to you. Filing with your insurance carrier **does not guarantee** benefits will be paid to us. The balance remains your responsibility.

If at any time, your insurance changes, you must notify us immediately.

*****McArthur Counseling Center does not file secondary insurance.*****

****Please complete the following REQUIRED information…Policy Holders:**

_____ _____

****Legal Name of Policy Holder** ****Date of birth**

_____ _____

Social Security Number ****Relationship to client**

_____/_____/____/_____ _____

ADDRESS City St. Zip Phone

_____ _____ _____

Insurance Company Name Insured ID # ****Employer**

Thank your for understanding our Financial and Insurance policy. Please let us know if you have any questions.

_____ _____

Signature of Client or Responsible Party Date