**Gem Moore, PhD**

**Foxcroft Psychological Services
2723 Foxcroft Rd., Ste. 311, Little Rock, AR 72227
(501) 225-2525**

**FINANCIAL POLICY AND MISSED APPOINTMENT POLICY**

Welcome to **Foxcroft Psychological Services**. Please read over our Financial and Missed Appointment Policy. If you have questions, feel free to ask me.

**FINANCIAL POLICY**

**Fees.**  Counseling sessions are 45 minutes long. The fee for a 45-minute session, either face-to-face or by phone, is **[Session Fee]**. A first-time patient is charged **[50% of Session Fee]** by credit card to hold their appointment time. This fee is non-refundable, but it is deducted from your first visit. Payment is collected at the first of the session. We also ask you to place a credit card on file for future billing.

**Charges.** Occasionally there are extra charges or other altered charges, but in your case the fee for a 45-minute session will be \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Insurance Patients.** If you have health insurance, Foxcroft will contact your insurance company and verify your insurance benefits. We will also file your insurance for you. If your insurance covers a portion of your therapy, we will wait up to 90 days for your insurance to pay their portion. **You will, however, be responsible for your deductible and co-pay or co-insurance. That portion of your care will be due at the time of your appointment. You will be responsible for all charges not covered by your insurance company.**

**Self-Pay Patients.** Patients without insurance, with high deductibles, or who choose not to use their insurance are responsible for the cost of care. Payment is expected at the time of service.

**Methods of Payment.** Foxcroft accepts cash, checks and major credit cards. There is a $20 returned check fee.

**Payment in Advance.** If I suggest more than 10 visits, you may pay for them in advance and receive a discount of 15%. Payment for multiple visits must be made by the third visit.

**MISSED APPOINTMENT POLICY**

Twenty-four hour notice is required for the cancellation of an appointment. **Appointments canceled with less than 24 hours notice will be charged your full fee.** **Your insurance company will not pay this fee; you will be personally responsible for it.** Appointments missed because of inclement weather will not be charged. The charge will be applied to your credit card on file.

 **I have read and agree to the above conditions.**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CREDIT CARD GUARANTEE**

**[ ] SELF-PAY PATIENTS**

If you:

* Are uninsured
* Have insurance that does not cover the cost of mental health counseling,
* Or choose to pay out-of-pocket for other reasons,

then you are responsible for full payment at the time of services. As a convenience to you, we will automatically charge your designated card below on the day of services.

We charge a **missed appointment fee** **of $80** in the event that you miss an appointment without giving **24-hours’ notice**.

**[ ] INSURANCE PATIENTS**

You are responsible for meeting your **deductible** and making **co-pays** or **co-insurance** payments at the time of service. As a courtesy to you, we will bill your health insurance provider on your behalf for the balance and wait up to 90 days for payment. Please remember, however, that you are ultimately responsible for payment.

On Day 90, if the bill has not been paid by your insurance company, we will charge your designated credit card below for the amount of the claim. Any payments made on these claims thereafter will be immediately refunded to you.

Your insurance provider does not pay for missed appointments. If you miss an appointment without giving **24-hours’ notice**, you will be charged a **missed appointment fee** of \_\_\_\_\_\_\_\_\_\_\_\_\_.

**I agree to the above terms and authorize you to charge my card.**

SIGNATURE DATE

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CREDIT CARD:  AMEX  VISA  MC  DISCOVER

CARDHOLDER'S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BILLING ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 CARD # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EXP. DATE \_\_\_\_\_\_\_\_\_\_

THREE DIGIT CID NUMBER \_\_\_\_\_\_\_\_\_

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**INSURANCE INFORMATION**

**Your name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy holder’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ID number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**May this doctor be consulted for continuity of care? Yes No**

* **If yes, please fill out the form “Consent for Coordination of Care.”**

**BY SIGNING BELOW, CLIENT AUTHORIZES THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THEIR INSURANCE CLAIMS PURSUANT TO HIPAA LAW AND THIS OFFICE’S NOTICE OF PRVACY PRACTICES.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Client Signature Date**