



5824 S. 142nd St., Ste. A, Omaha, NE 68137
402-594-4410

Office Financial Policy and Billing Agreement

Name (print): _____

Insurance Coverage:

- I agree to contact my insurance company to verify the mental health benefits. (You pay for your insurance. It is your responsibility to know the benefits of your policy) _____ initial
- Should I 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 and any deductible is not yet met, it is due at the time of the service/appointment. _____ initial
- I understand any co-pay is due at the time of service. If a minor, the person that accompanies the child will pay the co-pay. _____ initial

Payment/Scheduling:

- 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. A late charge of \$50.00 may be assessed if notice is not provided. _____ initial
- If a client does not show for a scheduled appointment a no-show charge of \$50.00 will be invoiced to the client. _____ initial
- Phone calls are billed for time spent on the phone at an hourly rate. _____ initial
- Texting or email may only be used for scheduling or canceling appointments. Any other use of these forms of contact is considered implied consent on the client's behalf that they chose to make that information vulnerable or released to possible third-party sources (aka: computer hackers). _____ initial
- Statements will not be sent to a third party without their written consent to pay on file. _____ initial
- Accounts that are not paid within 90 days may be sent to a collection agency. _____ initial
- Fees are subject to change at the discretion of the practice. _____ initial

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

X _____
Date:
Client Signature

X _____
Date:
Signature of Witness