Healing For All
Financial Agreement - Insurance and Workers' Compensation
Dr. Sherri Marie (Simpson) Broadwater
Board Certified Adult, Child and Adolescent Psychiatrist

Our clinical staff are providers on select insurance and managed care plans.

If we are a contracted provider for your insurance plan, we will bill the insurance directly. Payment of any applicable co-insurance, co-payment or deductible is due at the time services are rendered. If we do not have a contractual provider relationship with your insurance plan, full payment for services is due at the time services are provided.

I agree to pay my co-insurance, co-payment, or deductible before each appointment. ***Initial***_____

Some services may not be covered by health insurance. Charges for uncovered services will be your responsibility. This may include charges for telephone consultations, written correspondence, or reports in connection with evaluation or treatment, and charges for appointments that are missed or canceled without at least 48 hours prior notification.

We will try to handle all insurance issues in order to save you that time, but the final responsibility for payment of charges for our services is yours. Every insurance policy varies with respect to the specific benefits and coverage provided. We will contact your insurance provider to learn of the benefits you have chosen and we will do our best to explain your insurance benefits to you. However, we encourage you to call your insurance company yourself to learn exactly what your mental health benefits are (they are often different from other medical benefits). When we call your insurance provider to verify your benefits, it is not uncommon that we are given erroneous, misleading, or contradictory information. Therefore, we cannot be responsible if the information we provide you is in error and your insurance ends up covering a smaller amount of your charges than you expect, or does not cover our services at all.

I agree to verify my mental health coverage and it is my responsibility to verify any insurance information provided to me by Healing For All, LLC. ***Initial***_____

If your insurance policy changes, please call our office to inform us of your new policy and bring your insurance card with you to your next appointment. Most policies have a limit to how long after an appointment the service can be billed to the insurance. Therefore, if you fail to notify us of a change in your health insurance policy in a timely manner, you will be responsible for the entire amount of the charges not covered by insurance.

I agree to pay for any and all the amount of my appointment if it is not covered by insurance coverage. ***Initial***_____

I authorize the release of medical information necessary to process any of my insurance claims or workers compensation claims and I authorize payment of medical benefits directly to **Healing For All** for services rendered. ***Initial***_____

If you are receiving workers' compensation, please inform us immediately if there are any changes including adjuster's information/address, fees or the terms of your workers' compensation.

I agree to inform Healing For All of any and all changes above. I am fully responsible for any outstanding payment owed to Healing For All in the event there is a lapse or end of my workers' compensation. ***Initial***_____

If I fail to notify the office about my inability to keep a scheduled appointment at least 48 hours prior to such appointment, I agree to pay a **$75 no show fee.** ***Initial***_____

Due to excessive weekend cancellations leaving slots unable to fill, a **$95 late cancellation fee** will now be charged for any Monday cancellation NOT DONE BEFORE NOON on the Friday PRIOR to the weekend. ***Initial***_____

Upon arrival I understand that I will be asked to leave credit card information on file.

I, the undersigned, agree that regardless of any insurance coverage, I am financially responsible for all charges generated for this patient including appointment fees, late and no show fees, medical records, letters, speaking with collaborating clinicians, teachers, attorneys, or other.

I understand that unpaid balances over 30 days past due may carry a late fee equivalent to 1.5% per month of that outstanding balance. I understand that unpaid balances over 90 days past due may be referred to a collection agency.

Party Responsible for Payment
First and Last Name (if someone other than the patient, identify relationship to patient)
_____
Email Address: _____
Physical Address: _____
Primary Phone: _____
Patient Name: _____

Signature: _____ Date:_____