SIOUXLAND CHILD & ADOLESCENT THERAPY SERVICES, LLC
FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. If you are uncertain of the cost for a specific service, we urge you to inquire with either your therapist or our billing personnel.

All patients must complete our Intake form before seeing a therapist.

Fees: ◆ Payment is Due at The Time of Service

Initial Assessment (not to exceed 60 minutes): $220.00
Individual, family or couples counseling: $170.00 (38 - 53+ minutes); $120.00 (16 - 37 minutes)
Psychosexual Evaluation/Assessment: $190 / hour
Court Preparation / Travel Time / Testimony: $275 / hour
Miscellaneous Services: $170 - $275 per hour - prorated
(Collateral contacts, review of collateral documents, phone contacts, generated reports or letters); group fees are variable based upon referral source

- **We Accept Cash, Checks, American Express, Discover or Visa/Mastercard**
- **AN Extended Payment Plan May Be Available with Therapist and Business Office Approval**

INTEREST: Interest will be charged at a rate of 1%/month (12% annually) to all unpaid balances 60 days or more delinquent.

Regarding Insurance:

- You are financially responsible for your balance regardless of possible insurance reimbursement.
- You are responsible to verify your insurance benefits. Any verification done by Siouxland Child & Adolescent Therapy Services, LLC is not a guarantee of coverage. Preauthorization / precertification is your responsibility. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company requires information from Siouxland Child & Adolescent Therapy Services, LLC you must inform our business office.
- You must provide us with your complete insurance information. We will not bill your insurance if we do not receive complete and accurate information.
- Your first visit, regardless of insurance coverage, must be paid 100%. Visits thereafter require a minimum 20% payment of your fee. Once an insurance payment has been received in our office, your co-payment can be adjusted accordingly.
- If your therapist is a participating provider with your insurance plan, you are responsible for payment of all co-pays and deductibles at the time of each service.

Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance plan. ***Please check your benefits!***

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we do not charge over what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients:

The parent(s) or guardian(s) signing this financial policy is responsible for the minor's account. Siouxland Child & Adolescent Therapy Services, LLC understands there are circumstances where another parent or guardian is responsible for all, or a portion or the minor's medical expenses. However, Siouxland Child & Adolescent Therapy Services, LLC is not a party to that agreement. Any and all parties who are to be billed for a minor's account must sign a financial policy.

For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan or payment is sent with the minor.

Missed Appointments or Late Cancellations:

Our policy is to charge for "no show" appointments at the rate of a normal office visit. Appointments that are not canceled at least 24 hours in advance are also subject to this fee. Please help us serve you better by keeping your scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

X_____ _____
Signature of Patient or Responsible Party — Patient Name – Please Print

X_____ Date:_____
Siouxland Child & Adolescent Therapy Services, LLC Witness Signature