Cynthia Benson, MS, LMFT, NCAC II
Practicing independently
8121 W. Quinault Ave. Suite F202 Kennewick, WA 99336

OFFICE POLICIES/FINANCIAL AGREEMENT
READ CAREFULLY!!

Special Accommodations: We are happy to provide reasonable accommodations to persons with disabilities. Please let us know in advance what you need.

Hours: Business hours are 9:00 AM to 5:00 PM (closed 12pm to 1pm for lunch). Individual clinicians may offer evening appointments. After hours calls are picked up by voice mail. In case of emergency, please call 911 or the Crisis Response Center at 783-0500.

Waiting Room: Our waiting room area is modest. Please **DO NOT** bring young children with you to your appointment. Our office cannot provide supervision for them to remain in the waiting area and, with the exception of family therapy, the topics at your appointment are inappropriate for their participation or observation

Financial Policy
This disclosure constitutes an agreement between the individual receiving service, their guarantor and any of the clinicians listed above who are practicing independently at this location.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refers to the clinician(s) you see at this location.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payments: The balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days from the date of the statement, unless other arrangements are approved in writing. Acceptance of late or partial payments (even if marked "Paid in Full") shall not waive any of our rights to collect the full amount due under this Agreement.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Required Payments: Any co-payments required by an insurance company **must** be paid by cash/check/credit/debit card **at the time of service.** Because this is an insurance requirement, we cannot bill you for co-payments. **A $10 fee will be added to your account if you do not pay your co-pay at time of service**. If you are unsure of your co-pay amount, you will need to pay 50% of the office visit at the time of the appointment.

Insurance: Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. **If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it.** If your insurance has a limit to the number of visits you are authorized, **YOU ARE RESPONSIBLE FOR TRACKING THE NUMBER OF VISITS YOU HAVE REMAINING.** Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company, and you may be responsible for a higher portion of our fee. We **DO NOT** bill secondary insurance.
Rebilling Fee: We reserve the right to assess a rebilling fee of 1.5% (18% annually) to accounts that are 60 days past due.

Returned Checks: There is a fee (currently $25, subject to change without notice) for any checks returned by the bank. If your check is returned to us on more than one occasion, we will require payment in cash for any services rendered.

Missed Appointment Fee: All evaluation and treatment visits are by appointment only. An appointment is a commitment to work together at a designated time and place. Clients who fail to attend a scheduled appointment, or cancel after 10am two business days prior to their scheduled appointment, will be charged a fee (currently up to the full amount of the session) **REGARDLESS OF THE REASON FOR THE NO SHOW OR LATE.** **Cancellations MUST be made no later than 10am two business days prior.** **Client Initials:** _____

Late Arrivals: If you arrive more than 15 minutes beyond your scheduled time, the clinician will have the option whether or not to see you. If you are not seen, the appointment may be considered a "No Show". If the clinician chooses to see the client, then a full session fee will be charged, regardless of the actual time spent in the session. If a No Show or Late Cancellation fee is assessed, this fee must be paid before a new appointment is scheduled. Your insurance will NOT cover missed appointments fees. Patients with three missed appointments will be asked to transfer their clinical care to another provider.

Reminder Phone Calls: In an effort to help you avoid fees for missed appointments or late cancellations, this office offers to call you the business day before your appointment to remind you. These reminder calls are made between 8am and 6pm. If you give us a telephone number to call to remind you of an appointment, you are giving us permission to make a reminder call to you at the number provided. You also authorize us to identify our office and leave the date and time of your appointment on an answering machine or with any individual who answers the telephone should you not be available. The only information that will be given is the name of the staff member making the call, the name of the clinician the appointment is with, the appointment date, the appointment time, and a return phone number if it is requested. No other private health information will be given out. If you do not wish to receive a reminder phone call for your appointments, you need only inform us that you do not wish to receive a call. **This reminder call is a COURTESY and in no way relieves you of the responsibility of remembering and attending your appointments.**

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer to collection your past due balance to an attorney, you agree to pay all attorneys' fees that we incur plus all court costs and **a processing fee of $50.00.** In case of suit, you agree the venue shall be in Benton County, Washington.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parents' responsibility to collect from the other parent, as a divorce degree is an agreement between those parties and the court, not with our provider.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-Signature: If this, or another, Financial Policy is signed by another person that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. Refusal to sign this agreement will result in denial of services.

Current Fees for services: by Masters Level Therapist

Initial Evaluation	
45-50 mins session	$200.00
Individual Therapy	
45-50 mins session	$150.00
75-80 mins session	$225.00
Family/Marital/Couples	
45-50 mins session	$150.00
No Show/Late Cancellation*	$150.00

*Which must be paid before next session

Release of Benefits:
I authorize my insurance benefits to be paid directly to the treating therapist named on the heading of the form. I understand that I am financially responsible for non-covered services. I also authorize the release of any medical information necessary to process claims.
I have read the Office Policies and Financial Agreement and have been offered a copy of this agreement. I understand that by my signature below I am consenting to all of the terms of these Office Policies and the Financial Agreement. Failure on my part to read the document does not constitute a release from any of the obligations set forth in this agreement.

By executing this agreement, you are agreeing to pay for all services that are received.

Client: _____ _____
(13 years and younger must sign along with guardian) **DATE**

_____ _____
Financially Responsible Individual **DATE**

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