Dear Patient,

Welcome to Behavioral Care Services. We appreciate the opportunity of being of service to you. Our office is dedicated to excellence in patient care. To maintain our high standards, we believe that it is important that we communicate our policies to you. Please take a moment to read and become familiar with these policies. Should you have any questions, the office staff would be happy to help. By presenting these policies in advance, we can avoid any surprises or misunderstandings. We appreciate your time and your understanding.

Patient Financial Responsibility Agreement

- **Payment Responsibility:** I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or my family members. I understand that payment or co-payment is due at the time services are rendered unless special arrangements have been made. Length of time for therapy sessions are 1 hour for an initial consultation and 50 minutes for follow-up sessions.

- **Phone Consultations**: In order to be flexible and responsive, most of the therapists at Behavioral Care services are available for phone sessions and to speak with the clients at times when necessary. I understand, however, that all calls exceeding ten minutes will be billed in a pro-rated fashion on the basis of my session fee. Further, insurance will not cover the cost of a phone session; therefore, this fee is an out of pocket expense.

- **Charges for Additional Services**: I understand that charges will be added to my account for other professional services rendered. This charge will be in increments of 15 minutes and Behavioral Care Services will always discuss additional charges with me. Other professional services include extended contact via email, consulting with other professionals with my permission, preparation of records or treatment summaries, and the time spent performing any other service I may request.

- **Appointments & Cancellations:** I understand that, I am required to provide at least 24 hours advance notice if unable to keep the scheduled appointment because the scheduled time slot has been reserved exclusively for me and/or my family members. In the event that I do not provide 24 hours advance notice, I am financially responsible for the reserved appointment. Behavioral Care Services may make exceptions and waive the fee, at its discretion, for emergency or unusual circumstances. I understand that insurance companies do not provide reimbursement for cancelled sessions. Repeated missed appointments may result in termination of therapy. There may be a time when my therapist may need to cancel my appointment for an emergency; Behavioral Care Services will make every effort to reschedule me and / my family in an appropriate time frame.

- **Returned Check Fee**: I, the undersigned, agree to pay a fee of $25.00 for any check returned by my financial institution regardless of reason.

- **Delinquent Accounts**: I understand that my account may be turned over for collection and I will be responsible for all costs of collection monies owed, including court costs, collection and attorney fees. I further understand that if I fail to make any of the payments for which I am responsible in a timely manner, I will be charged a 1.5% service charge monthly on the remaining balance.

I fully understand and agree to the above policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

Patient Name_____
Last First Middle Initial

Patient/Parent/Guardian Signature_____

Printed Name: _____

Date:_____