illuminate
THERAPY & WELLNESS

Financial Policy and Agreement

Thank you for choosing Illuminate Therapy & Wellness, LLC (IT&W) as your mental health counseling provider. We are committed to providing you with the best care possible. Please read the following information carefully and completely. Should you have any questions, please discuss with your therapist. Your clear understanding of our Financial Policy and Agreement is important to our professional relationship. **You must sign and date the form prior to beginning your treatment.**

INSURANCE

Insurance coverage is a contract between the patient and the insurance carrier. You are responsible for all co-payments, deductibles and payments for non-covered services, which are due at the time of treatment. We accept MasterCard, Visa and Discover, HSA/FSA debit and credit cards, as well as cash or check. Although we do our best to verify your eligibility for mental health services, IT&W is not responsible for denied claims and verification of insurance benefits is an estimate, not a guarantee of benefits. It is the responsibility of the patient to know and understand the benefits of his/her particular insurance. You are advised to seek assistance in understanding your mental health benefits by contacting the Human Resources Department with your employer or by calling the "Member Services" number on the back of your card. In the event that a claim is denied, you are personally responsible for the full invoice amount.

There are numerous insurance networks, yet our clinicians are not a part of all these networks, and, therefore, we have not agreed to accept a reduced fee from all insurance companies. Many insurance companies pay a different percentage of charges based on whether or not the clinician is a part of their network. If you choose to see one of our clinicians who is out-of-network with your insurance carrier, you are responsible for the out-of-network benefits assigned for the type of service being billed.

Claims will be submitted to your primary insurance company on your behalf for services rendered. We are unable to directly bill secondary insurers. Billing any other secondary insurance must be done by the patient. The balance due on your account after receipt of payments from primary insurers must be paid in full by you. We will provide you with the documentation necessary for you to file your secondary insurance claim. Changes in your insurance company or insurance coverage (such as annual renewal, expiration or type of coverage provided) may affect your financial responsibility. Please notify your therapist if you change your insurance plan or anticipate a change in your coverage.

Client Initials: _____ Therapist Initials: _____

If you prefer to file your insurance on your own, we will be happy to provide you with a "superbill" to assist you if you file your own insurance claims.

FEES AND PAYMENT

Payment is expected at the time of service. Should you be enrolled in a PPO or managed health care plan, we require that you make your co-payment (including deductibles and/or any co-insurance amount) at the time of each visit. If you are not using insurance, you will be responsible for the full fee for the service provided.

Credit Card on File

You are required to provide credit card information and authorization for your therapist to charge your card automatically in the case of missed appointments or late cancellations (less than 24 hours prior to scheduled appointments). A receipt for each payment is available upon request.
Your credit card will be saved on file through our secure practice software. You will have the option at the time of your session to pay co-payments/deductibles via your credit card on file as well. Please inform your therapist if you do not want your credit card on file to be processed in this manner. The credit card on file will also be billed directly for all balances owed (including insurance payment beyond the 60 days mandated by Illinois law).

Returned Checks

In the event that a deposited check is returned due to insufficient funds, a $50.00 fee will be charged. In addition, you will be responsible for the original amount owed. If such situations arise, you may be asked to pay either with a credit card or cash for subsequent sessions.

Missed Appointments

Your appointment is reserved exclusively for you. If you miss your appointment or cancel with less than 24 hours notice, your therapist is unable to care for another client. Thus, missed appointments, or those cancelled with less than 24 hours of your scheduled appointment time are subject to a missed appointment fee of $125.00.

Non-Covered Services

We regard mental health care as collaboration between patient, therapist and other members of your treatment team; including but not limited to psychiatrists, school personnel, primary care physicians, etc. At times, phone consultation, reading or writing documents, formal assessments, report writing, attendance at school staffings, etc. may be requested to ensure cohesive and quality treatment is being established on the client's behalf. You are fully responsible for payment for the time required by your therapist to complete any non-counseling services, which will be billed to you at the following rates:

Phone Calls: There may be times when you need to speak with your counselor over the phone. These phone calls are not meant to take the place of a face-to-face session in our office, but may be related to a question or advice. No charges will be assessed for routine phone calls for appointments and routine clinical consultation lasting less than 15 minutes. Charges for calls lasting longer than 15 minutes will be assessed at a rate of $37.50/15-minute increments, or $150.00/hour. Please be advised that insurance companies do not reimburse for crisis phone calls.

Client Initials: _____ Therapist Initials: _____

Written Work: If you request any letters, forms, or any other paperwork to be completed please allow a minimum of 1 weeks' notice and the fee structure is as follows - $150.00 per hour; prorated based on time spent at 15-minute increments of $37.50 each. Please note that requests to complete FMLA or disability paperwork requires at least 6 weeks advance notice to properly assess whether we can support your need.

Record Copying: The office will charge a minimum $25.00 copying fee for the copying of medical records up to 50 pages. After 50 pages, the rate will be $0.25 per page and $25.00 per hour. Postage/delivery costs will also be applied.

Out of Office Activities: If therapists are asked to attend meetings outside the office (school staffing, or observations, etc.) the billable time is $175.00/hour and for travel to/from any such event is billed at 50%: $87.50/hour, which can be prorated.

Legal/Court related Matters: We do not provide therapy for the explicit purpose of providing records or evidence for legal matters. Our purpose is to support our clients to achieve therapy goals, not to address legal issues that require an adversarial approach. Clients entering treatment are agreeing to not involve us in legal/court proceedings. If you do become involved in legal proceedings that require our participation, fees for our professional time are billed at $200.00/hour, including preparation time, with travel time being billed at 50%: $100.00/hour.

Responsible Party

If the patient is a minor (or is subject to guardianship under Court Order), a parent or guardian must:

1. Consent to treatment
2. Accept responsibility for payment for our services
3. In the case of divorced or separated parents, other arrangements (including Court Orders and Decrees) notwithstanding, the parent or guardian signing this form will be the party billed and agrees to be personally liable for any and all co-payments and other balances outstanding.

Billable Party Name: _____ **Phone:** _____

Relationship to Client: _____

Address: _____

Street City State Zip

Thank you for taking the time to read through our Financial Policy and Agreement. If you have any questions, please do not hesitate to ask us, we are here to help you. Please sign and date this page indicating that you have read and understand this policy and agree to abide by it.

Client Initials: _____ Therapist Initials: _____

I have read, understand, and agree to the Financial Policy and Agreement of Illuminate Therapy & Wellness provided in this document and authorize IT&W to send correspondence relating to dates of service and charges to the billable party stated above.

Client Signature

_____Date_____

(Client or Parent/Guardian if Minor/Personal Representative; 12 years or older)

Partner/Spouse or Parent/Guardian Signature

_____ Date_____

(If Applicable)

Witness Signature:

_____ Date: _____

Acknowledgement-Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices from Illuminate Therapy & Wellness. I am also aware that a Notice of Privacy Practices is obtainable by going to www.illuminatingyou.com and clicking on the “Client Forms” tab. Forms are also available on location.

Client Signature

_____Date_____

(Client or Parent/Guardian if Minor/Personal Representative)

Partner/Spouse or Parent/Guardian Signature

_____Date_____

(If Applicable)