# CLIENT FINANCIAL RESPONSIBILITY of Alliance Child & Family Solutions ("ACFS")

Thank you for choosing Alliance Child & Family Solutions "ACFS" for your mental health needs. Our goal is to provide and maintain a positive provider-client relationship. Letting you know in advance about our office policies allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

**First, we must emphasize that as your healthcare provider, our relationship is with you, not your insurance company.**

1. **Insurance**:
   a. As a courtesy, we attempt to verify benefits and file claims to your insurance at no charge. If we have an agreement with your insurance company, we will honor the rates, co-payments, co-insurances, and deductibles defined in our agreement. You are responsible for all co-payments, deductibles, and non-covered charges on the day of your service.
   It is your responsibility to know your benefits and we encourage you to contact your insurance company as well.
   b. It is your responsibility to keep ACFS up to date with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment for the visit at the self-pay rate of $150/Initial Visit or $125/Follow-Up Visit.**
   c. Please always feel free to contact our Billing Department with any concerns, questions, or information regarding your account at 817-851-2042 x 888 or billing@acfstexas.com.

2. **No Insurance, Self-Pay Services, and/or High Deductibles**:
   a. If you do not have insurance, choose not to utilize your insurance for services, or have a high deductible, you are expected to pay all fees at the time of service.
   b. Fees may be eligible to be reduced upon completion of the "Financial Assistance Plan Application" along with supporting documents (proof of income). This application is processed in-house as a courtesy to our clients who may be facing financial difficulties in paying for their services. We do not check your credit when determining if you are eligible for a lowered discount from our Cash Pay fees or patient deductible.
   c. Once the "Financial Assistance Plan" is submitted along with related income verification documents, as well as New Client Forms, our Billing Manager will review and send a signed copy back to you with the discounted amount to be applied for each appointment. The "Assistance Plan Application" is available on our website or can be obtained from staff members or the Accounting Department.

3. **Credit Card Storage & Usage**
   a. To ensure good stewardship of our services, we require that you place a confidential credit/debit card on file to better manage collection of co-payments, deductibles, co-insurances, and no show/late cancellation fees.
   b. The information is stored in a secure system that complies with Payment Card Industry Data Security Standard. We require this information in order to continue offering comprehensive services and compassionate solutions to all of our clients with the same accessibility and reasonable cost that we have been able to maintain to now.
   c. Regarding treatment of services for minors in which a court order specifies payment responsibility between two legal guardians: As a courtesy to the parents at their request, the Billing Department will split the patient responsibility of the patient portion to be collected at the time of service between each parent when both cards are on file.
      - Should one of the two legal guardians be unwilling or unable to put a card on file despite court orders indicating responsibility of payment, the minor cannot continue to be seen for treatment unless all client responsibilities are paid in full.
      - If there is any discrepancy or issues, please contact the Billing Department as soon as possible. If too many issues arise with the collection process, the Billing Manager can decide at any time to stop collecting fees between parents and parents would need to decide who will pay as the primary and seek reimbursement from the other parent.

4. **Frequently Asked Questions about Credit Card Pre-Authorization**

Q. How does the pre-authorized payment procedure work?

A. It starts when you fill out this form along with provide your insurance paperwork:

- This form is used to specify that insurance payments are to be made directly to the agency. Once your healthcare provider receives payment from your insurance company, he/she will bill your account automatically for any fees not covered by your insurance, including deductibles and copayments.
- And, this form is used to automatically bill your account for recurring visits with established co-payments, co-insurance, and/or late or no show fees.

Q: Is my credit card information accessible or stored by your office?

A: No. Your card information is only needed one time and your data is captured by Stripe, a PCI Service Provider Level 1 that is an accredited merchant services company and is encrypted and stored by them only. The Office Manager and Accounting Department have password encryption services to access our pay systems and can pull your account by name but only the last 4 digits of your card information is seen.

**By my signature below, I am indicating that I have read and understand all of the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I understand that I have the right to ask questions of the Therapist or Staff about the above information at any time.**

**I also acknowledge by my signature below that:**

1. I authorize Alliance Child & Family Solutions to keep my signature on file and to charge my account for:
   a. Balances of charges not to exceed $150.00 per claim for: clean claims with balances for co-insurances and deductibles which are reflected on your explanation of benefits.
   b. Recurring charges for ongoing treatments with established co-payments, co-insurance, and/or any late and/or no-show fees.
2. I assign my insurance benefits to the practice listed above. I understand that this form is valid for four (4) years unless I cancel the authorization through written notice to the health care provider. I understand I must notify the practice of any card renewals, insurance changes, or other account changes.
3. I have read and understood these statements and have had ample opportunity to ask questions about the information, and seek clarification of anything unclear to me.

**These signatures are signed and submitted as of today's date, ________________**

| ______________________________ | ______________________________ |
|---|---|
| **Printed Name of Client (**or Legal Guardian | **Signature of Client** *(or Legal Guardian)* |

***NOTE: The signatures on this form are considered valid and true regardless of whether hand signed or signed electronically through IntakeQ, AdobeSign, DrChrono, or another approved electronic venue, that I am consenting to all of the above statements with my electronic signature, even if the signature does not appear on the exact lines above.**