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

As your Service Provider, our relationship is with you, not your insurance company.

1. **Insurance:**
   a. **It is your responsibility as the Client to know your benefits**; you will NOT be called in advance of your appointment regarding verification of benefits. We encourage you to contact your insurance company so you can be informed of any copays, fees, deductibles, or limitations with your insurance plan.
   b. As a courtesy, we attempt to verify benefits and file claims to your insurance at no charge. Insurance payments are to be made directly to the agency.
   c. 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.
   d. 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 for Service Providers with Full Clinical License.**
   e. 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. **Credit Card Storage & Usage:**
   a. **We require all Clients to place a confidential payment method on file** (credit card, HSA, or checking account) to manage collection of co-payments, deductibles, co-insurance, or no show/late cancellation fees.
   b. Payment information stored in a secure, encrypted system that complies with Payment Card Industry Data Security Standard. The Referrals and Billing Departments have access to our pay systems and can pull your account by name but only the last 4 digits of your payment method is seen.
   c. 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.

3. **Payment Processing**
   a. **Payment Receipts are sent via email from our system (DrChrono, ClearGage) and may list Anastasia Taylor on receipts, even if you are receiving services from a different Service Provider.** Receipts, patient statements and payment plans will come from the following email: **sso.acceleratedpayments.com**. Please ensure you check your Spam folder for this correspondence
   b. Our Billing Department will automatically bill your account for recurring visits with established co-payments, co-insurance, and/or late cancellation or no show fees.
   c. Once ACFS receives payment from your insurance company, the Billing Department may bill your account automatically for any fees not covered by your insurance, including deductibles and copayments or differences between the estimated costs and actual fees for service.

4. **Financial Assistance Options:**
   a. **CASH PAY BY PROVIDER LEVEL**: As a Cash Pay client, there are no requirements to take advantage of these plans. If interested, select the level of Service Provider for services when scheduling your visit:
      - Masters-Level Practicum Students = $50 / Initial Visit + $25 / Follow Up Visits
      - Midlevel Providers (LMFT-A, LMSW, LPC-Associate) = $100 / Initial + $75 / Follow Up Visits
      - Clinical Therapist (LCSW, LMFT, and LPC) = $150 / Initial Visit + $125 / Follow Up Visits
   b. **REDUCED FEES BASED ON INCOME:** 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.
   c. **GRANT-FUNDED PROGRAMS:** At various times, we may have grant-funded programs that offer services for low to no-charge for qualifying participants. *Some of these programs include: GAPP, COVID-19 Hardship Program, Essential Workers Program*. Inquire with our Billing and Referrals Department for current program offerings and information to see if you qualify.

5. <u>**Other Charges or Fees**</u>
   a. **Letters** (including Treatment Summaries, Emotional Support Animals, IEP Recommendations, etc.) may be assessed an additional fee of $50.00 to be paid prior to receiving written documentation.
      - **Please allow 48 business hours from the time of payment to draft and submit requested documentation. These items can generally NOT be provided same day.**

   b. **Court Involvement** (see our Court Involvement for more information about fees and services)
      - **Subpoenas should be received as far in advance as possible, though at least two weeks' notice is preferred.**
      - **Subpoenas for records must be requested directly from a judge due to HIPAA regulations to protect PHI.**
      - **Assuming all requirements are met, Court Involvement Fees for records or appearance must be paid in full by the requesting party at least 48 hours prior to the appearance.**

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 this Policy as part of my Services and Treatment.

I also acknowledge by my signature below that:

1. I authorize Alliance Child & Family Solutions ("ACFS") to keep my signature on file and to charge my account for:
   a. Balances of charges <u>not to exceed</u> $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 (ACFS). I understand that this form is valid for four (4) years unless I cancel the authorization through written notice to the health care provider.
3. I understand I must notify the practice of any card renewals, insurance changes, or other account changes.
4. 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.

This Policy is signed, submitted, and effective as of today's date, ________________

____________________	____________________	____________________
Name of Client	**Name of Legal Guardian** (if applicable)	**Signature** (Client/Legal Guardian)

*NOTE: The signatures on this form are considered valid and true regardless of whether hand signed or signed electronically through IntakeQ, AdobeSign, DocuSign, DrChrono, OnPatient, or another approved electronic venue, and 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.