

FINANCIAL POLICY

Name: _____

DOB: _____

I am committed to providing you the best possible care in the most cost- effective manner possible. Please read the following financial policy.

I accept cash, checks, Venmo and most credit cards. I prefer that copays and deductibles be paid with cash, checks or Venmo, if possible. As of July 1, 2019, any credit card payments for services rendered by Lisa B Kelly, LCSW, LLC will have an **additional processing fee of 5%** included in the total payment. Any payments made by cash, check or Venmo will not have an additional processing fee.

Venmo is an alternative way of making payment to this therapist and privacy settings have been adjusted by the therapist to ensure privacy on the therapist's Venmo account. If you chose to make payment thru Venmo, understand that it is your responsibility to change privacy settings on your Venmo account to protect your confidentiality (ensuring that the transaction is visible to the sender and receiver only).

If I am in your insurance network of providers or if you have out of network benefits, I will bill the insurance company directly after services are rendered. If you do not have an out of network benefit, I may bill you for services provided and will provide any documentation you need to submit for reimbursement from your insurance company. Due to some of the insurance contracts I have signed, I am required to collect all copays, coinsurances and deductible amounts at the time of service. I ask that you call your insurance company to check on your coverage to limit your out of pocket expenses. I will file any secondary insurance once for you, but it is always your responsibility to follow up on any unpaid or denied claim.

When you make an appointment with me, I reserve that time for you. If you cannot make the scheduled appointment, please contact me as soon as possible. If you notify me with less than 24- hour notice of a need to change or cancel the appointment, I reserve the right to charge you a late cancellation fee. Any no show or no call to any appointment might not be rescheduled. If this happens more than once, I reserve the right to discharge you from my practice.

If you cannot afford to pay your account in full, I will work with you on a payment plan.

I charge a \$40 bank charge fee for any returned check. If I do get a returned check, I reserve the right to make your account a cash pay only account. If your account becomes delinquent, I reserve the right to charge you a \$25 collection handling fee and send your account to a collection agency. If I have to send your account to any agency, you automatically will be responsible for any court cost associated with the legal collection process to the extent permitted by law.

By signing below, you agree to my financial policy. The construction and enforcement of this agreement shall be governed by the state of Indiana. I reserve the right to change this policy at any time and will notify you of any changes.

Signature of responsible party _____ Date _____