Harrisonburg Center for Healing
Client Financial Agreement

Thank you for choosing us as your Behavioral Health provider. we are committed to providing you with quality care. We ask all patients to review and sign this policy. A copy can be provided upon request.

1. **Insurance**: We accept and participate in most insurance plans. If your insurance is not a plan we participate in, Payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.

2. **Patient payment**: ALL copayments and deductibles are to be paid at the time of service. This arrangement is part of your Contract with your insurance.

3. **Registration**: All patients must complete our patient information form, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time filing restrictions; if a claim is not filed within 30 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains

4. **Claims**: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract.

5. **Credit and Collection**: If your account is more than 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance has remained unpaid, it may be sent to a collection agency and you are responsible for their fees in addition to your balance. If an account is sent to collections, it is the policy of this office to discharge the patient.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO ABIDE BY ITS GUIDELINES.

SIGNATURE:____ DATE:____________