Bridging Connections

Bridging Connections is comprised of *Connections Christian Counseling Center, Bridgewater Counseling and Consulting, Serenity Grace Counseling and Central Ohio Counseling Services.*

OFFICE & FINANCIAL POLICIES

RIGHTS & RISKS: Deciding to start counseling means being willing to discuss what troubles you and be open to change. You may remember unpleasant events, stir up emotions and/or alter close relationships. Feel free to ask questions about any aspect of the counseling process. If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report.

CONFIDENTIALITY: Information shared will be held in confidence and will not be released without your written consent, unless required by law. The courts may, in select cases, subpoena counseling records. It is understood that information regarding treatment and diagnosis may be provided to your insurance company. Feel free to discuss other limits or exceptions of confidentiality.

APPOINTMENTS: All office visits are by appointment and are scheduled through your counselor directly. Please arrive on time, as you use up your own time when you arrive late. The typical billing time is 55-60 minutes. We realize that emergencies come up that can affect your ability to attend your appointment. In case of illness or emergency, please notify us no later than 8:00 am the day of the appointment and leave a message if you get the voice mail. Failure to cancel a scheduled appointment by 8:00 am will result in an **$80.00** charge for the missed appointment. Insurance companies will not pay for no-show charges.

EMERGENCIES: Our office is not equipped to accept after-hours emergencies. **If a crisis situation arises**, contact the local 911 emergency hotline or go immediately to your local hospital emergency room.

BASIC FINANCIAL POLICY: Payment in full is due at the time service is provided for self-pay clients unless prior arrangements have been made. **Co-payments are due at the time of service**. A **$10.00** service fee may be added to the bill per month when balances are not paid in full.

CLIENTS WITH INSURANCE: We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. **If your insurance requires a referral or prior authorization, it is your responsibility to assure that one is available to our office prior to or at the time of your service.** Our office contracts with many insurance carriers, please contact your insurance prior to your appointment to verify you are receiving care from a participating provider. Co-payments, coinsurance and deductibles are due at the time of service. If you have questions about your benefits or your insurance carrier's decision to pay or deny your claim, please contact the insurance carrier directly. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

COUNSELING RATES:

Insurance Billing Rates		**Self-Pay Billing Rates**	
Initial Assessment	$185.00	Initial Assessment	$150.00
45 Min. Individual	$145.00	45 Min. Individual	$ 95.00
60-80 Min. Individual	$170.00	60-80 Min. Individual	$115.00
45 Min. Family/Marital	$175.00	45 Min. Family/Marital	$120.00
20-30 Min. Individual	$ 90.00	20-30 Min. Individual	$ 60.00
60-90 Min. Group	$ 70.00	60-90 Min. Group	$ 40.00
Crisis Stabilization	$195.00	Crisis Stabilization	$150.00

Above are rates for counseling sessions with a Licensed Clinical Social Worker.

COURT APPEARANCES*:* If a clinician is subpoenaed to go to court or asked to appear on your behalf, **YOU** are responsible for the daily fee of $1,000. This needs to be paid in full 48 hours before the court date. This is not covered by insurance!

MINOR CLIENTS: In the case of divorced or separated parents, the person accompanying the child or children is responsible for payment at the time of service. If the person financially responsible is not the one accompanying the minor, the financially responsible person will have to sign the Office and Financial Policies form and provide an address for billing. Otherwise, billing will be sent to the person signing the form. The Office and Financial Policies form must be signed in order for services to occur.

SELF-PAY CLIENTS: Individuals without insurance coverage, or those who have coverage but choose to pay out of pocket, will pay the agreed amount of _$_____ per Initial Assessment and _$_____ per 45 minute session.

ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurance please read and sign below. I hereby assign all benefits for any services furnished to me by Bridging Connections (Bridging Connections is comprised of *Connections Christian Counseling, Bridgewater Counseling, Serenity Grace Counseling and Central Ohio Counseling Services).* This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Bridging Connections, to release all information necessary to secure the payment.

COLLECTIONS: All efforts will be made to work with you on your balance. In the event payments are not made, we will pursue all necessary actions to recoup those balances after 3 months delinquency.

COPIES OF CLINICAL RECORDS: Clients or their legal representatives may request copies of part or all of their clinical records at any time. This request can be made to the client's clinician. Bridging Connections charges $50 (plus mailing rates, if applicable) for records.

I have read, understand, and agree to the above office and financial policies. I have discussed these policies with my counselor and all questions have been answered to my satisfaction. I have been offered a copy of these policies to take with me if I desire.

I hereby acknowledge that I have received a copy of Bridging Connections Notice of Privacy Practices. I understand this document provides information on how my health information may be used or disclosed by Bridging Connections and my rights with respect to my health information.

_____

Signature of Client Printed Name Date

If client is a minor:

_____

Signature of Parent/Guardian Printed Name Relationship to Client Date

_____

Witness Printed Name Date