ADOLESCENT & FAMILY COUNSELING CENTER, LLC
350 South Main Street, Cheshire, CT 06410 203 271-1234 /// 72 North Street, Suite 204, Danbury, CT 06810 203 790-1234

MEMO

TO: All Clients and Client Families
FROM: Herbert Jay Rosenfield, LCSW, A&FCC Director
DATE: June 1st, 2022
RE: **OUR RELATIONSHIP AND OUR FINANCIAL PRACTICES**
Thank you for the opportunity to be "Helping You Solve Life's Problems!" sm

We strongly believe the your seeking any type of counseling assistance is a sign of strength. It shows your willingness to take some risks and to make some changes in order to achieve gains and successes toward you own life-goals.

As part of our counseling relationship, we each need to be clear in our communications in all areas -- including our financial arrangements. This information is about our normal "Financial Practices". If you have any questions or difficulties with any of them, please raise them with you clinician or with our Administrative Staff, so we can work them out to our mutual satisfaction.

Please read this information, initial each section as "Read and accepted", sign the **3** acknowledgements in page 2, and return the form to your therapist. A copy of "Financial Practices" is also given to you for your records. Thank you!

FINANCIAL PRACTICES

(A) FEES for scheduled appointments and other professional services:

* Most Intake Interviews are 90 minutes; our normal session of psychotherapy is 50-60 minutes.
  The Masters-level therapist Intake Interview fee is $195.00; the usual session fee here is $145.00;

* Your Behavioral Health Insurance Company has likely contracted a lower fee per session, comprised of any client co-payment plus the insurance payment [after your meeting any deductible that your insurance requires].

* Fees for other services -- Educational/Psychological Assessments, Evaluations, Groups, Courses, Workshops, Programs, Presentations, Tutoring, Court, & Consultations -- are listed on brochures and available upon request.

______ Please initial as *"Read and accepted"*

(B) PAYMENTS for professional services:

* Fees / Co-payments are to be paid at the time of the session, unless an alternative arrangement had been worked out with the therapist. Please make out your check to "Adolescent & Family Counseling Center" or to "A&FCC".

* You are responsible for your fees for professional services, whether or not you have Medical/Insurance coverage.

* Most of our clients are very responsible about their financial obligations. Clients who do default on their financial obligations revoke their right to confidentiality. They will be liable for all reasonable collection costs, including a monthly rebilling fee, agency fees, court costs and / or legal fees.

______ Please initial as *"Read and accepted"*

(C) CANCELLED, BROKEN, OR MISSED APPOINTMENTS:

* Our Clinicians must plan their schedules and we have reserved an appointment time for you that other clients wish to fill. Therefore, if you are unable to keep your scheduled appointment, a 24-hour notice must be given of your "need to cancel".

* If you "Break an Appointment" [giving less than a 24-hours' notice], if we are unable to fill your scheduled appointment time with another client, we will charge you for the professional time reserved for you; and .

* If you "Miss an Appointment" [fail to come here or arrive too late], we will charge you for that professional time.

______ Please initial as *"Read and accepted"*

(D) MONTHLY STATEMENTS:

By the middle of the next calendar month, you will receive a current financial statement of your account, as of the first of that month. If you have any questions regarding your statement, balance, or insurance, please do call us.

______ Please initial as *"Read and accepted"*

(E) **INSURANCE COVERAGE:**

* The clinician serving you or your family member must be on your insurance panel, or you must have "out of network" provisions on yours, or you have chosen to pay out-of-pocket. You are responsible, prior to your 1st session, for calling your insurance company to clarify your deductibles &/or copayment for mental health services. Please inform your clinician of that information.

* To facilitate our clients' use of their employment's insurance benefit, we complete and submit insurance claims for most of our clients, for possible coverage for our mental health services to the client.

* Managed-Care plans require our submitting "Out-Patient Treatment Reports" (OTRs) – containing demographic, history, diagnostic, and treatment plan information -- to their Behavioral Health staff to confirm "medical necessity" for approval of therapy services. Insurance Companies contracts require the collection of co-payments.

* You are responsible to inform the A&FCC of changes in your insurance information, such as new coverage or loss of coverage. Failure to inform us in time will result in our not receiving an "Authorization to Treat"; you will then be financially responsible for the total charges for services received.

* You are responsible for the costs of professional services as you receive them, regardless of your coverage. If your insurance carrier allows direct payment to providers, as most policies do, we will expect your authorization for direct payment on the bottom of this memo. If your insurance carrier will only send the payment directly to you, you are legally responsible for conveying that full payment to the A&FCC.

______ Please initial as *"Read and accepted"*

(F) ADJUSTED FEES AND ALTERNATE PAYMENT SCHEDULES:

* An "adjusted fee" for psychotherapy services or an "alternate payment schedule" for other services of the Center may be worked out with the Director or a designated staff member, based on a confidential assessment of need.

______ Please initial as *"Read and accepted"*

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Agreement to Financial Practices and Fees:

I/We have read and understand the above Financial Practices and have received a copy of this statement.
I/We agree to the terms stated above for services to me/us and/or my family.
I/We understand & agree our Fee is $ _____; We have Deductible of $_____; Co-Payment/Coinsurance $_____.

Signed: ____ Relationship to Client: __Self __Parent __Guardian
Signed: ____ Relationship to Client: __Self __Parent __Guardian
Date: _____________

Insurance Permission for Release of Information:

I/We authorize the Adolescent & Family Counseling Center, LLC, to release to my insurer any information necessary to process the claims for professional services.

Signed: ____ Relationship to Client: __Self __Parent __Guardian
Signed: ____ Relationship to Client: __Self __Parent __Guardian
Date: _____________

Assignment of Benefits:

I/We give my/our insurance company permission to make the payment of benefits related to treatment directly to "*Adolescent & Family Counseling Center, LLC*". You are permitted to use my/our signature(s) as "Signature(s) on File".

Signed: ____ Relationship to Client: __Self __Parent __Guardian
Signed: ____ Relationship to Client: __Self __Parent __Guardian
Date: _____________