OUR MEADOWS

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Client Care & Financial Agreement

Welcome to Our Meadow of Eagle River, Alaska. The following is a statement of our Financial Policy, which we require you read and sign prior to receiving treatment.

INSURANCE & PAYMENT

I hereby authorize the release of pertinent medical information to my insurance carriers for the purpose of treatment and payment. I am aware that health insurance coverage varies and while insurance carriers may use terms such as customary, reasonable, prevailing, etc. to limit their coverage, I am ultimately responsible for payment of all charges for services rendered by Our Meadows and any other charges as a result of the treatment rendered. I understand that I will be responsible for any co-payments, deductibles, co-insurance, or any services that are not considered medically necessary by my insurance company and that I must pay my co-pay/co-insurance and or deductible at the time of service. I understand I am responsible for informing the office about changes to my policy that may affect my coverage and that I must notify the office of insurance changes within 30 days of the change otherwise I will be responsible for billing my own insurance. Insurance companies do not allow retroactive billing for services rendered beyond certain time frames. I understand I will be responsible for full payment of fees if Our Meadows is not informed in writing about changes to my insurance before services are rendered.

SELF-PAY / NO INSURANCE

I understand that if I do not have insurance, I am expected to pay for my visit in full at the time of service. Our Meadows will work with everyone on a case by case basis regarding self-pay/no insurance concerns.

NO SHOW FEES

I understand and agree that if I fail to keep my scheduled appointment and I do not give at least 24-hours' notice of cancellation I may be charged for the scheduled time. If my session cannot be conducted vial alternate means such as a Telebehavioral health platform there may be missed appointment charges imposed. One missed appointment will be considered "grace"; thereafter the missed appointment charge will be $60.00 for the first missed appointment, $80 for the second and $140 for three or more missed appointments. I understand that I am solely responsible for this missed appointment fee and that it will not be billed to my insurance.

COLLECTIONS

Payment for services received at Our Meadows is the responsibility of the client, regardless of insurance status. In the event the client fails to pay the balance or fails to set up a payment plan with Our Meadows within ninety (90) days of the date of service, the client's account may be turned over to collection. In the event it is necessary to turn my account over to collection, I understand that I will also be responsible for all costs of collection, including attorney fees and interest charges.

PRIVACY AND COMMUNICATION

At no time shall any communication with or in this office be recorded by any party. I understand that the phone number or email address that I supply can be used by the staff of Our Meadows to contact me about any matter and leave a message if needed. During that communication, the staff of Our Meadows can identify who they are and that they are calling from Our Meadows. If another person answers the phone at the given number, the staff of Our Meadows can leave a message with that person and identify who they are and supply them with the office contact information. I understand that I will receive a bill to the address I supply detailing what insurance has paid and/or what is owed. This bill will state what services were given and the name of the "responsible party" on front of the envelope. The bill will be delivered by the United States Postal Service from Our Meadows on a regular basis. The mailed envelope will also have the return address to Our Meadows on the upper left-hand corner.

I have read and fully understand the Client Care and Financial Agreement as outlined above. I understand that this Authorization shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, from this date forward until it has been revoked in writing. I consent to treatment by the staff of Our Meadow for myself, or my dependent.

Client Name: _____

Client (or guardian) Signature: _____ **Date:**_____

Printed Name if Parent or Guardian: _____