

**ARIZONA FAMILY RESOURCE COUNSELING CENTER
FINANCIAL INFORMATION**

I UNDERSTAND THAT IF I MISS AN APPOINTMENT WITHOUT CANCELLING BY 4:00 PM THE **BUSINESS DAY** PRIOR TO MY APPOINTMENT, I WILL BE CHARGED A \$50 FEE. MISSED APPOINTMENTS ARE NOT COVERED BY INSURANCE COMPANIES, THEREFORE THE CHARGES WILL BE MY RESPONSIBILITY.

ALL COPAYS MUST BE PAID AT THE TIME OF THE APPOINTMENT

Some managed mental health programs involve a co-payment. It is your responsibility to determine whether or not services are covered under your plan and to pay any charges not covered.

As you are probably aware, mental health benefits have been subject to a great many changes over the past few years. We have continued to provide the same high quality of patient care, while adjusting to the many cost cutting measures that have been put into effect. However, it has become increasingly apparent to us that we must implement the following policies:

1. Current insurance guidelines state that the duration of standard office visits vary with the services provided, and their reimbursements are based on that length of time. Should additional time be needed, you may be subjected to additional charges.
2. The following services are generally not covered by insurance benefits: extended telephone calls (over 5 minutes), letters, reports, copies of medical records and faxes. Should you require any of these services, you will be charged an additional fee. The fee may vary depending on the request.

Insurance Authorization: I authorize release of information, including copies of medical records to my insurance carrier, managed care company, clinical/case manager, primary care physician, as needed to fulfill insurance requirements for processing of my claims or as needed for treatment planning and management required by my insurance carrier.

Assignment of Benefits: I authorize payment of insurance benefits for services rendered to Arizona Family Resource/Counseling Center.

Arizona Family Resource Counseling Center will not become involved in disputes between you and your insurance company, other than to supply factual information as necessary. **You are responsible for any balance that your insurance company has not or will not pay.** If your insurance company has not paid, denies benefits or if you have any questions or complaints, please contact your insurance company.

Signature of patient/parent or legal guardian

Date