COLLABORATIVE
COUNSELING *TMS*

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Insurance and Financial Policy

1. All co-pays and/or charges must be **paid in full** at the time of service.
2. CC TMS accepts most insurance plans. Any contract that obligates your insurance carrier to pay for a portion of your healthcare is between you and your insurance carrier. CC TMS, in collaboration with the client, will be in contact with insurance carriers to verify benefits and facilitate the reimbursement process for services rendered. Depending on the insurance plan, your financial responsibility for services rendered will vary based on deductibles and out of pocket maximums.
3. The benefits investigation and financial agreement provided to you by CC TMS is an estimate of your financial obligation, insurance payments are subject to change based on your policy's claim and benefit determination. The processing of the claims by your insurance company may change your amount owed. If the amount owed changes based on your insurance claims processed for services rendered, you are financially responsible for payment in full of the remaining balance owed.
4. CC TMS staff will obtain all referrals/authorizations on your behalf required by your insurance plan, including the clinical explanation for medical necessity. If it is necessary for insurance authorization and approval, CC TMS will request client assistance.
5. We accept all major credit cards including Visa, Master Card, American Express, Discover, Check and Cash payments.
6. A $50 fee will be charged for missed treatments without 24 hours' notice, with the exception of an emergency or other urgent matters. This fee must be paid in full before another appointment can be scheduled or services provided.
7. In the unlikely event that you default on payment for any amount due, we will place your account in the hands of our attorney for collection or legal action. You will then be charged an additional fee equal to the cost of collection, including attorney fees and court costs incurred as permitted by the laws governing these transactions. Once this occurs you will forfeit the opportunity to be treated in our practice.

By signing this document you are agreeing to pay for our services in full and acknowledge that you have read and fully understand its contents.

Signature: ____ Date: ____________________
(Parent or guardian, if patient is a minor)

Signature of Witness: __________________________________ Date: ____________________