Jessica Sauer, LCSW
Brand New Day Counseling, LLC
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Phone: (407) 733-5392 • Facsimile: (407) 386-8237
www.brandnewdaycounseling.net

FINANCIAL POLICY

As part of an effort to provide the best possible mental health care to you, I would like to explain my financial policies in advance.

Client Name:____ Date:______________________

Name/Relationship of Financially Responsibly Party:____

1. Your health insurance is a contract between you, your insurance company and your employer. I will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, or coordination of benefits. My professional services are rendered to you, not the insurance company. Therefore, payment for services is ultimately your responsibility.

2. If you have a referral-based HMO or PPO insurance plan, it is your responsibility to obtain initial referrals or authorizations. Not all therapy services or psychiatric conditions are part of a covered benefit by all insurance plans. Please understand that if your insurance does not pay for a particular service, you will be responsible for the payment in full. It is your responsibility to understand your plan benefits. I only file with your primary insurance. It is your responsibility to file any additional insurance.

3. Please be advised it is the member's responsibility to ensure that preauthorization has been obtained before the service is performed. Issuance of a preauthorization is not a guarantee of payment. When submitted, the claim will be processed in accordance with the terms of the member's benefit plan. To obtain preauthorization for any future outpatient Behavioral Health service, please call the number listed on the back of your insurance identification card for Behavioral Health or Mental Health services.

4. Please inform me of ANY changes in your benefits or changes in the company that insures you PRIOR to your appointment. If, by your failure to provide me with current information, your insurance company subsequently denies me payment, you will be held financially responsible for those unpaid charges.

5. Your deductible, co-payment and any other fees incurred are due at the time of your visit. I accept cash, Visa, MasterCard, American Express and Discover cards.

6. Cancellations must be provided at least 24 hours in advance of the scheduled appointment. Cancellations not made prior to this timeframe are subject to a late cancellation and/or no show fee of $60.00.

7. Any insurance claims that are not paid by your insurance company are subject to the self-pay

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rate of $120.00/session.

8. Accounts that are 90-120 days past due may be turned over for collection.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

Signature of Financially Responsible Party __________________________ Date ___________________

Effective 08/11/2021