CFG CENTER FOR FAMILY GUIDANCE, PC

**Financial Responsibility Policy**

Thank you for choosing us as your Behavioral Healthcare provider. We are committed to providing you with high quality health care. In order to make sure our patients are well informed about our financial responsibility policy, we require each patient or guarantor to read this policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance** We participate in many insurance plans, including Medicare. If you are not insured by a plan with which we have a provider agreement contract, payment in full is expected at each visit. If you are insured by a plan with which we have a provider agreement contract, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

3. **Non-covered services** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance** All patients must complete our patient information form before services can be provided. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of one or all insurance claims submitted to your insurance provider for payment.

5. **Claims submission** We will submit your claims and assist you in any way we reasonably can to help get claims for services provided to you paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim, the balance will be billed to you.

*Marlton Office*
765 E Route 70, Suite A-100
Marlton, NJ 08053

*West Deptford Office*
875 Kings Highway, Suite 100
West Deptford, NJ 08096

*Westampton Office*
116 A Burrs Road
Westampton, NJ 08060

Phone: 856.983.3900
Fax: 856.810.0110
Web: www.ctrfamilyguidance.com

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**7. Nonpayment** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise arranged. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

**8. Missed appointments** Our policy is to charge for missed appointments not canceled with more than 48 hours advance notice. These charges will be your responsibility and billed directly to you, and cannot be billed to your insurance provider. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. I have read

and understand the payment policy and agree to abide by its guidelines:

_____ _____

**Signature of patient or responsible party** **Date**

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