Progressive Care Associates, Inc.
3415 Old Highway 41, Suite 750 Kennesaw, GA 30144
(678) 574-8313 | FAX (678) 574-8315

Financial Agreement

Cancelation/Missed Visit Policy

Non-emergency cancellations require 24 hours' notice. Non-emergencies include vacations, preplanned medical appointments, family events, parties, sports events, lack of babysitter or anything that is not designated as "emergency" (see below). The session must be canceled no later than 24 hours before the appointment. If non-emergency cancellations become excessive, the client may lose his or her weekly slot in the clinician's schedule. **If the session is not canceled with 24 hours' notice the client will be assessed a $50.00 fee.** Failure to arrive on time for your scheduled session or not being prepared to pay the full cost of your session at the time of arrival (without prior arrangements) will also constitute a missed visit/cancelation fee. You may leave a message on the voicemail on weekends or after hours to cancel an appointment or contact the scheduling department during business hours. **Appointments cannot be scheduled or cancelled via email** as it is not always a reliable, confidential source and not monitored 24/7. Please note that **insurance companies do not pay for missed/cancelled appointments, so you will be responsible for the missed visit/cancelation fee. Emergency cancelations require notification by at least 2 hours**, or as soon as it becomes knows that you will not be able to arrive on time for your scheduled session. Emergency cancellations are accepted only for illness, illness of a family member or death in the family. These sessions must be canceled within 2 hours of the scheduled appointment on the day of the appointment. Please do not come, or bring your child, to the office with a fever, strep, unidentified rash, diarrhea, vomiting or any highly contagious illness. You or your child must be fever-free for 24 hours prior to the session. If you or your child arrives ill, you will be dismissed and charged for the session. **_____INITIAL**

Dismissal Policy

When you schedule an appointment with a therapist the office holds a time slot for you. Because this office holds a time for your session, you are essentially promising to fulfill that slot. We take careful attendance. If you exceed a cancellation rate of 25 percent or higher you will receive a written notice that your slot is in jeopardy. This policy includes emergency and non-emergency cancellations. If you plan on discontinuing services for any reason, you must give this office notice or you will be billed for the missed sessions. This office must also give you 30 days' notice if treatment will be discontinued for breach of attendance policy. Should your services be discontinued, your therapist will provide you with a list of referrals. **_____INITIAL**

Court Attendance, On-Call, and Communication with Attorneys/Other Professionals

Progressive Care Associates, Inc. bills at the rate of $200.00 per hour for court attendance and requires credit card information to be on file. The hourly rate begins when the therapist leaves the office location and a fee for two hours will be paid prior to court attendance, ($400.00) and is non-refundable if less time is needed. If the court attendance exceeds two hours, your credit card will be billed for the remaining time. Payment is for the therapist's time and not necessarily their testimony. Therefore, the fees are expected to be paid regardless of whether the therapist testifies or not. If you request for your therapist to be on-call for court attendance, Progressive Care Associates, Inc. bills at the rate of $60.00 per hour for on-call and requires credit card information to be on file for payment to be charged. The hours requested for the therapist to be on call will immediately be charged to your credit card on file and is non-refundable. **_____INITIAL**

Communication Other professionals/Report writing:

Progressive Care Associates, Inc. bills at the rate of $100.00 per hour for any type of communication with attorneys/other professionals/report writing (phone calls, letter writing, email, etc). You are responsible for providing credit card information prior to any communication your therapist will have with their attorney/other outside professional. A minimum of 30 minute increments will be billed to your credit card on file and is non-refundable. Communication fees paid by check will require bank clearance before services will be rendered. After payment is received and processed, please allow up to 7 business days for paperwork/communication to be completed. **_____INITIAL**

Records Request

Progressive Care Associates, Inc. bills a flat rate of $25 for records to be copied and faxed/given to the client. If records need to be mailed, an additional fee of $10 is assessed to cover certified mail and postage. After payment is received and processed, please allow up to 7 business days for copies to be provided and/or mailed. **_____INITIAL**

Payments/Billing

Private Pay: If you do not have insurance, payment will be due at the time of service. We require a minimum of 100% of the balance to be paid at the time of service. **_____INITIAL**

Insurance: Although we are contracted with several insurance companies, it is your responsibility to make sure that our therapist participates in your specific plan. If our therapist is not a participating provider for your plan, you may still select our office for your medical care; "out of network" benefits will apply. It is also your responsibility to know your insurance benefits. Our office will not advise you of your insurance benefits. Please contact your insurance company at the Customer Service phone number printed on your insurance card if you have questions pertaining to coverage. As a courtesy to our patients, we will file insurance forms from our office. We must have this insurance information prior to your appointment. We will request an update to your information annually. Please present your insurance card at each appointment. A photo ID is required at your first visit. We make every effort to verify insurance prior to your appointment. If our office is unable to verify your insurance eligibility, you will be required to pay for your visit at the time of your appointment. If you provide the correct insurance information to our office in a timely manner, we will file a claim on your behalf. We will refund to you any portion that is determined to not be your responsibility. You are responsible for paying all co-pays at the time of service. Co-pays, co-insurance, deductibles and non-covered services cannot be waived by our office, as it is a requirement placed on you by your insurance carrier. Failure to pay your portion of services rendered will be reported to your insurance company and could result in termination of your insurance plan. **_____INITIAL**

Billing: If you receive an invoice from our office for a balance due, it is because that is the balance your insurance policy requires that you pay. Please contact your insurance company first if you believe there is a problem. The balance on your invoice should be equal to the "Patient Responsibility" portion on your Explanation of Benefits that you received from your insurance company plus any "non-covered services" (less any copay that was collected at the time of service). If there is a discrepancy, please call the billing office immediately to advise us. **_____INITIAL**

Authorization for Credit Card Payments

Visa, MasterCard, American Express, or Discover cards are all accepted. By completing the information below, you agree to have your credit card information stored securely by Progressive Care Associates, Inc. until your file has been closed. You also authorize your therapist or billing representative to charge your credit card for any outstanding financial responsibilities. Charges are typically made for such items as no show/late cancellation fees, copay and deductible payments, and copying and consultation fees.

Name as it appears on your credit card:

_____

Card type (please check): ☐Visa ☐ MasterCard ☐American Express ☐ Discover

Card number: _____/_____/_____/_____

Expiration date: _____/_____ CVC: _____ (3-digit code on reverse of card)

My signature below indicates that I have read, understand, and agree with the provisions of the Financial Agreement.

_____ _____

Signature Date

_____ _____

Witness Date