Psychotherapy Associates of Chicago, PC

Insurance Release and Billing Policies

As a courtesy to our clients we accept many insurance plans and submit claims on their behalf. It is the client's responsibility to provide accurate and complete insurance information, including promptly notifying our office after any changes to the insurance policy or to his/her contact information.

Client Responsibility: It is the client's responsibility to pay for all services provided, even if they are subsequently denied by insurance. These non-reimbursed costs may include, but are not limited to, deductibles, copayments, missed sessions, unauthorized sessions, and non-covered procedures.
Copayments: Clients are expected to provide copayment at the time of service. If writing a check, clients are asked to write it in advance in order to make the best use of time.
Authorizations and Limited Sessions: The client is responsible for obtaining any necessary initial insurance authorizations. Subsequent authorizations may require involvement from both client and therapist. Additionally, clients should be aware that many insurance plans cover only 12 to 25 visits per calendar year. Clients are strongly urged to know this detail of their policy and plan accordingly. It is not the responsibility of the therapist or billing agent to track authorized sessions.
Cancellations and missed sessions: The client will be charged $100 for a session cancelled without a 24-hour notice. Insurance plans cannot be billed for these missed appointments. Due to the fact that your time is reserved in advance, there are no exceptions to this rule including issues related to work, weather, illness, or childcare difficulties.
Claim Rejections: If the claim is denied by an insurance carrier for any reason, including but not limited to; deductibles, non-authorizations, pre-existing conditions, or non-response, the credit card will be charged immediately. If there is a reasonable argument for appeal, the office manager will submit additional paperwork. If the insurance company eventually submits payment, we will reimburse the client.
Collections: In the unlikely event that a client fails to remit payment and the credit card is denied, we will be forced to send the account to collections and/or legal action. Clients are held responsible for all associated fees, including lawyer fees, collection fees, administrative fees, and any additional expenses.
Credit Cards: To ensure payment, clients are required to provide a credit card number or pay at the time of service. Our billing service will charge this credit card in accordance with the policies listed above and in the document "Treatment Guidelines." Psychotherapy Associates of Chicago PC and its agents are not required to provide additional notification regarding these charges. If clients no longer want this card to be used they are required to notify the therapist, in writing, to request this change.

I,_______________________________________, have read, understand, have had time to ask questions, and agree to the insurance and payment guidelines listed above. I understand and agree that I am responsible for the cost of all services not covered by my insurance plan. Additionally, I hereby agree to have my credit card charged for all outstanding debts.

I hereby authorize Psychotherapy Associates of Chicago PC and its agents to submit health insurance claims for all services and receive direct payment from my insurance carrier. I understand that if I fail to consent my insurance company cannot be billed for my sessions and I will be required to self-pay. I authorize Psychotherapy Associates of Chicago PC and its agents to release information from my record that pertains to filing and providing adequate documentation for any insurance claim and I have a right to inspect and copy the information to be disclosed. It is my responsibility to notify Psychotherapy Associates of Chicago PC in writing if I do not want my claims to be submitted in the future. I understand this consent expires ten years from today's date and that I have a right to revoke the consent at any time.

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Signature of Client (or guardian if client is a minor) Date Expiration Date

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Witness Date Expiration Date