All fees are to be paid at the time of service. **Checks should be made payable to Melinda Halford.**

Phone calls made after hours will be handled by voice mail and returned on the following day. Since my services are for outpatient diagnostic and psychotherapy services only, I cannot guarantee around-the-clock availability. Therefore, if you should experience an emotional or behavioral crisis and I cannot be reached immediately by telephone, you and your family members are instructed to call 911, or 1-800-273-TALK (8255), or go to your nearest emergency room. Calls that are returned at the request of the client which pertain to treatment issues will be billed at the rate of a regular session if they exceed 15 minutes.

Both the therapist and the client will have the right to renegotiate fees within the above limits due to changes in financial status. Fees for testing, written treatment summaries, consultations, or other special services will be outlined upon request. Payment for services is due at the time services are rendered (before each session) and is the responsibility of the client or guarantor. The client and/or guarantor are ultimately responsible for payment since services are provided to the client and not to his/her insurance company. Insurance companies usually require a specific clinical diagnosis, determined by the therapist, when claims are filed for mental health services. This diagnosis may become a permanent part of your insurance record. While I don’t file out-of-network insurance for you, I can provide the necessary paper work for you to file your own insurance.

Unless otherwise agreed to by the therapist, accounts with outstanding balances of more than 2 sessions will result in the suspension of therapy until the outstanding balance is made current.

Counseling services are by appointment only. **Because the appointment time is reserved for you, it is necessary to charge for appointments that are not cancelled 24 hours in advance.** Failure to provide a 24-hour notice of cancellation means that another person is not able to use that appointment time. Exceptions to this include unexpected illness and inclement weather.

***Please read the following carefully and sign in the space provided below the applicable section.***

**SELF-PAY**

I have no insurance coverage or am waiving the use of insurance for privacy reasons. Therefore, I understand that I am responsible for payment in full at the time of service for services provided for me and/or my dependents.

I understand that I may be charged for any session which was missed or not cancelled with at least 24 hours advanced notice to Melinda Halford.

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Signature of Patient/Legal Guardian/Responsible Party

**OUT OF NETWORK SERVICES**

I have insurance, however Melinda Halford is not a contracted provider with my insurance company. I am responsible for payment in full at time of service for services provided for me and/or my dependents. I will be provided with a “Super Bill” which will contain the necessary elements (including date of service, place of service, provider/license/NPI#, medical billing code, diagnostic code, and fee for service) for submission to my insurance company for any applicable reimbursements. It is my responsibility to check with my insurance company prior to obtaining services to understand what services may be covered as well as the reimbursement requirements and procedures of my particular insurance company.

I understand that I may be charged in full for any session which was missed or not cancelled with at least 24 hours advanced notice to Melinda Halford. (Missed sessions are NOT covered by insurance and therefore not eligible for reimbursement.)

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Signature of Patient/Legal Guardian/Responsible Party

**IN NETWORK INSURANCE SERVICES (please sign both sections)**

I am covered by an insurance company who has contracted Melinda Halford as a network provider. I understand that it is my responsibility to contact my insurance company to verify network providers and to understand my mental health coverage. This includes, but is not limited to, applicable deductible requirements, amount of copay required for services, precertification requirements, limits to number of visits, authorized services, etc. I understand that as stated in insurance agreements “benefit information is not a guarantee of payment”, and I agree to pay for services provided for me and/or my dependents which are not covered by my insurance plan. I understand that I may be charged in full for any session which was missed or not cancelled with at least 24 hours notice to Melinda Halford. (Missed sessions are NOT covered by insurance.)

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Signature of Patient/Legal Guardian/Responsible Party

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I hereby authorize Melinda Halford to release any information necessary to obtain treatment authorization and to process insurance claims. I request payments of benefits to be made to Melinda Halford for services provided for me and/or my dependents. I understand that I am responsible for paying any required copayments or deductible at the time of service.

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Signature or Patient/Legal Guardian/Responsible Party