INSPIRE WELLNESS
Psychological, Educational and Performance Services
266 Harristown Rd, Ste 209
Glen Rock, NJ 07452

FINANCIAL SERVICE GUIDELINES

YOU ARE RESPONSIBLE FOR UNDERSTANDING YOUR COVERAGE

Bring your insurance card with you to each office visit. It is your responsibility to be aware of your insurance coverage, including but not limited to policy provisions, deductibles, limitations and authorization requirements. If your plan or insurance coverage changes and /or you are issued a new card, it is your responsibility to notify us immediately. We are not responsible for charges that are denied because we have relied on information that is not current. In the event a claim is denied, you will be personally responsible for your bill and/or any outstanding charges.

INSURANCE COVERAGE

Inspire Wellness is an Out of Network provider. As a courtesy, we attempt to verify that your coverage is active and verify your Out of Network, Mental Health benefits before your first appointment with our office. However, you are responsible for finding out all information regarding your out of network coverage prior to your appointment. You are responsible for satisfying the out of network deductible. The deductible is determined by your individual contract with your insurance carrier. Co-insurance fees are your responsibility. Your insurance company expects co-insurance fees be collected at time of service.

Select insurance companies send reimbursement checks directly to the patient/insured for services rendered by Inspire Wellness. Any reimbursement sent directly to the insured for services rendered by our doctors or clinicians must be remitted to Inspire Wellness within 14 days of receipt. Failure to do so will result in Inspire Wellness charging the credit card on file the reimbursement amount.

SELF PAYS

All patients without valid insurance or without Out of Network coverage on their insurance policy are considered self-pay patients. All self-pay patients are required to pay at the time service is rendered. Please be prepared to make this payment with the front desk personnel at the start of your visit.

CANCELLATION POLICY

The time we set aside for your appointment is important and affects our efforts to efficiently serve all our patients. If you are unable to keep your appointment you must call the office to provide us with at least 24 hours notice in advance of your appointment. Failure to give the required 24-hour notice will result in you being charged a $100.00 cancellation fee. **This fee cannot be billed to your insurance company and will be your direct responsibility.** Please note, appointments *rescheduled* due to a Late Cancel or No Show will not offset the charge regardless of whether the session is in the office or virtual**.**

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PAYMENT POLICY

Inspire Wellness will attempt to verify your Out of Network benefits and submit claims to your insurance carrier directly, as an out-of-network provider. However, it is your responsibility to meet your annual out of network deductible, as well as pay the co-insurance fee at the time of service. All patients without valid insurance or without Out of Network coverage on their insurance policy are considered self pay patients. All self-pay patients are required to pay at the time service is rendered.

Check Policy:

When you use a check to pay for our services, you authorize us to represent your check to your bank for collection either electronically or by paper draft. In the event your check is retuned for any reason, you understand you will be charged for any additional applicable fees as permitted by law.

Credit Card Policy

Inspire Wellness requires a credit card on file for the select insurance companies who send the reimbursement checks directly to the patient/insured for services rendered by Inspire Wellness. Inspire Wellness requires the insurance reimbursement that is issued by the insurance provider for services rendered by Inspire Wellness be remitted to our office within 14 days of receipt of the check or the credit card on file will be charged.

In addition, Inspire Wellness reserves the right to charge the credit card on file for any applicable deductible or co-insurance fees or if you are not in compliance with the cancellation polices.

If Your Account Becomes Delinquent:

We will do our very best to work with you. Our billing office may contact you by telephone, email and/or by mail. If you do not respond to our attempts to discuss your balance we may refer your account to an outside collection agency. Once your account has left our office for collections, we can no longer communicate with you regarding your balance and you must address your circumstances with the agency. You will also be directly responsible for any additional fees associated with the collection of your balance. You should also be aware that referral of your balance to a collection agent may constitute grounds for your discharge from the practice.

If you have any questions regarding our guidelines please feel free to contact our Billing Department at 201-564-7331.

Your signature below acknowledges that you have read, understood our policies and your responsibility regarding the charges and fees that you have incurred as a result of services that you have received from Inspire Wellness.

Name of Patient_____ Date_____

Name of Parent/Guardian (if under the age of 18) _____

Signature of patient or parent/guardian _____ Date_____

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Credit Card Information

Name on card _____

Credit card number_____ Expiration Date_____CVV_____

Visa☐ Mastercard☐ American Express☐ Discover☐ Billing Zip Code _____

Please Initial

_____ I understand Inspire Wellness reserves the right to charge my credit card for any applicable deductible or co-insurance fees should payment not be made at the time of the appointment.

_____ I understand Inspire Wellness reserves the right to charge my credit card if I am not in compliance with the cancellation policy.

_____ I understand as a member of an insurance provider that reimburses the insured rather than the provider rendering service, Inspire Wellness reserves the right to charge my credit card the reimbursement payment issued by the insurance provider if the reimbursement check is not brought to Inspire Wellness within 14 days of receipt of the payment. In the event Inspire Wellness charges my credit card the reimbursement payment, the member can then keep the check issued by the insurance provider.

_____ I understand Inspire Wellness reserves the right to pass on any applicable chargeback or bank fees permitted by law associated with a disputed credit card charge or returned check.

_____ I understand that failure to comply with the policies may result in termination of services. In addition, Inspire Wellness reserves the right to forward the account to collections and report the account to a Credit Bureau.

Name of Patient_____ Date_____

Name of Parent/Guardian (if under the age of 18) _____

Signature of patient or parent/guardian _____ Date_____

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PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD. Your understanding and cooperation is greatly appreciated.

Client Information

Name _____ Date of Birth _____ ☐M ☐F

Address _____

City _____ State _____ Zip Code _____

Cell # _____ Alternate # _____

Email Address _____

Insurance Information

Name of Insured _____ Date of Birth _____ ☐M ☐F

Address ☐Same as Client _____

City _____ State _____ Zip Code _____

Cell # _____ Alternate # _____

Email Address _____

Relationship to Insured ☐Self ☐Spouse ☐Child ☐Partner ☐Parent ☐Other _____

Insurance Company _____

Plan ID # _____ Group # _____

Secondary Insurance: Yes☐ No☐ Medicare Yes☐ No☐ Medicaid Yes☐ No☐

Secondary Insurance Company _____

Member ID# _____ Group# _____ Phone _____

Emergency Contact

Name _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Cell # _____ Alternate # _____

Email Address _____

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HIPAA Acknowledgement and Approval of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been given the right to review the HIPPA Notice of Privacy Practices prior to signing this consent. I also further acknowledge and approve the uses and disclosures of my PHI as described in the HIPPA Notice of Privacy Practices. A more complete description of the uses and disclosures of my health information is available in the office upon request. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at anytime to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

_____

Client's Name & Date of Birth (MM/DD/YYYY)

_____

Signed (Patient or Legal Representative for Patient)

_____

Date

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CLIENT CONSENT TO THERAPY

Please complete section (A) if the person receiving services is 18 years or older and complete section (B) if the person receiving services is under the age of 18.

A. I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I agree to pay the initial evaluation fee and agreed upon session fees. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with an Inspire Wellness therapist. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by an Inspire Wellness therapist. I am over the age of eighteen.

   Client Signature: _____Date: _____

   Witness: _____Date: _____

B. I/we _____ have full custodial guardianship of my child _____. He/she is currently under the age of 18, and I/we consent that he/she may be treated as a client by an Inspire Wellness therapist.

   Parent or Guardian signature: _____ Date: _____

   Client Assent (if over the age of 14): _____ Date: _____

   Witness: _____ Date: _____

Parents: Do not leave the office while your minor child is with his/her therapist. A responsible adult must be present during your child's visit. It may be necessary for the therapist to speak with you at some point during your child's session.

VERIFICATION STATEMENT OF THERAPIST

This document was discussed with the client and questions regarding fees, diagnosis, and treatment plan were discussed. I have assessed the parent's or guardian's mental capacity and found her or him capable of giving an informed consent at this time.

Initial of Therapist _____ Date _____

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Responsibility of Payment & Consultation Fees

If your child is under the age of 18 years, please provide your marital status:

☐ Married ☐ Separated ☐ Divorced

If your marital status is SEPARATED or DIVORCED, please read and complete this document.

Name of Child: _____

RESPONSIBILITY OF PAYMENT

Will fee for service be shared between parents: Yes ☐ No ☐

If Yes, please indicate name of each parent providing payment and details of fee split:

Name: _____ Details of Fee Split: _____

Name: _____ Details of Fee Split: _____

If No, please indicate name of parent providing payment:

Name: _____

Payment of services is due at the time of the session. Please be advised, late cancel charges and/or consultation fees will adhere to the Responsibility of Payment as indicated above. PLEASE NOTE, sessions that are solely with an individual parent, that parent is responsible for 100% of the session fee.

CONSULTATION FEES

Should our case require extensive follow-up which exceeds 30 minutes per week outside of session (i.e. communication with parent, guardian at litem, parenting coordinator, lawyer) there will be a $150 consultation fee, non-billable to insurance, which will be collected at completion of the service.

Your signature below acknowledges that you have read our policies and understand your responsibility regarding payments and additional charges that you may incur as a result of services provided by Inspire Wellness. ***Please be advised, the client will not be scheduled should this document not be completed & signed.***

Name of Parent: _____

Signature of Parent: _____ Date _____

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Consent to Email, Call and/or Text

By providing my telephone number (whether landline or wireless) and /or email address to Inspire Wellness, I expressly consent that employees of Inspire Wellness may contact me by email, telephone and /or text. They may leave a voicemail at any telephone number (whether landline or wireless) I have provided below to Inspire Wellness regarding any matter that is related to my treatment, my account and/or Inspire Wellness services including but not limited to the following: *my treatment, my condition and plan of care, the services rendered, communication made to me or related to my account, or my related financial obligations including, but not limited to, information about insurance coverage/eligibility, fees for service, payment reminders, delinquent notifications, appointment reminders, information about referrals and information about available treatment options*.

These communications may be transmitted by or on behalf of Inspire Wellness and it's employees using pre-recorded or automated voice messages, use of an automatic dialing device, or other technologies. I understand that providing my prior express written consent to receive such communication is not a condition of receiving services from Inspire Wellness. I understand I will be able to change my preferences at any time.

Patient Name: _____

Parent/Guardian Name (if under 18 yrs): _____

Patient or Parent/Guardian Signature: _____

Date: _____

Residential/Landline Telephone Number: _____

Cellular/Wireless Telephone Number: _____

Email Address: _____

If you have any questions regarding the above, please feel free to contact our Billing Department at (201) 564-7331