<u>INTERFACE APPOINTMENT AND BILLING POLICIES</u>

Patient Name: ________________________________ Date of Birth: __________________________

Below are the billing and appointment policies of Interface Center. **Please read and initial each.**

______ Appointments are made directly with your therapist **<u>ONLY</u>** at each session or by calling the therapist line at 860-354-5116 and selecting your therapist's ext. Please **<u>DO NOT</u>** call the business office to schedule appointments.

______ 24 hours notice is required for cancelling appointments. If you know you are going to be late or need to cancel an appointment please call your therapist at **(860) 354-5116** and leave a message at their extension as soon as possible. The answering service is available 24-hours a day. **<u>DO NOT</u>** call the business office to cancel appointments or to leave messages for your therapist.

______ A charge of **$25** will be applied for the **first** missed appointment or appointment cancelled without proper notice. Additional missed or cancelled appointments without proper notice will be a fee of **$60** per missed or cancelled appointment.

______ **ALL copays, co-insurance and estimated deductible amounts are due and payable at the time of service**, unless payment arrangements have been made in advance.

______ We will submit claims for you; however, it is your responsibility to immediately inform us of any insurance changes.

______ If your insurance has terminated or you are not eligible for benefits and you have not informed us you are responsible for all charges incurred during the lapse in coverage.

______ A $25.00 fee will be charged for returned checks.

______ Interest will be added to accounts at a rate of 1.5% per month for balances over 30 days past due.

______ Clients who have terminated therapy and have a remaining balance of more than 30 days may be turned over to a collection agency and/or an attorney, in which case all collection and/or attorney fees will be paid by the client or guarantor on the account.

Your signature below indicates that you have read and initialed the above policies and agree to abide by its terms.

____ ___________

Patient or Guardian Signature **Date**