INTERFACE APPOINTMENT AND BILLING POLICIES

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 **ONLY** at each session or by calling the therapist line at **860-354-5116** and selecting your therapist's extension. Please **DO NOT** call the business office to schedule appointments.

_____ At minimum of 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. **DO NOT** 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. Subsequent missed or cancelled appointments without proper notice will be a fee of **$60** per missed or cancelled appointment. Three or more missed appointments or appointments cancelled without proper notice within a 3 month period will result in termination of services.

_____ **ALL copays, co-insurance and estimated deductible amounts are due at the time of service**. Credit cards can be kept on file by completing the attached form. **Accounts requiring a paper statement to be mailed will incur a $10 billing fee.**

_____ As a courtesy, we will submit claims for you; however, **it is your responsibility to know your insurance benefits and financial responsibility**. It is also your responsibility to let us know of any insurance changes immediately.

_____ 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.

_____ 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 initialed and read the above policies and agree to abide by its terms.

_____ _____

Patient or Guardian Signature **Date**