Susan M. Knell, Ph.D., LLC

Financial Policy Statement

The patient or responsible party assumes responsibility for any financial obligation related to mental health care received. This Policy Statement must be signed before services are provided.

1. If you have an insurance co-payment, payment is expected at the time of the appointment. It is your responsibility to know the amount of the co-payment. You may be subject to a $5.00 late fee charge for non-payment of your co-payment on the date of your appointment.
2. Patients who do not come to a scheduled appointment without canceling at least 24 hours prior to the appointment will be subject to a cancellation fee/no show charge. This fee is determined by several factors, in the discretion of Dr. Knell, including the number of times you have missed an appointment, but will never exceed the total amount of the charge that would have been received for the session.
3. Patients with high deductible plans ($1,000 or more) who have not met their deductible may be asked to pay the following fees prior to their visit. $100 for the first visit, $50 for each subsequent visit. Patients will be refunded or billed for additional amounts as appropriate after claims are processed by their insurance company.
4. Patients with insurance are expected to pay any personal balance that is due as soon as their insurance company remits payment. Bills must be paid as soon as they are received in order to avoid further charges of $20 for each monthly rebilling fee.
5. Not all services are covered by all insurance plans. The patient or responsible party maintains the responsibility for verifying coverage.
6. Patients are responsible for payment in full of any non-covered services at the time the service is provided, including if they notify me prior to the service being performed that they want no information going to their insurance company.
7. Patients must provide sufficient notice regarding any prior authorizations or other forms necessary for their insurance companies to pay. Patients are responsible for any financial penalty incurred by failure to secure proper authorizations.
8. If there is an overpayment, money will be credited to the patient's account and ultimately refunded if there are no further services provided.

I accept cash, personal checks and credit cards (Visa, Mastercard, Discover). Returned checks are subject to a $30 processing fee. Balances over 45 days may be subject to additional rebilling fees. I encourage you to speak with me regarding any financial problems that may interfere with timely payment. Thank you for your cooperation with these policies.

I have read and understand the Financial Policy stated above and agree to these conditions. I am the patient or authorized to sign this document on behalf of the patient.

Patient name: ______________________________

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Signature of responsible party Date