HealingHearts
THERAPEUTIC SERVICES, PLLC

INSURANCE DISCLOSURE LIABILITY FORM

• **I understand that it is my responsibility to disclose all insurance information** to Healing Hearts Therapeutic Services, PLLC.
• **I understand that it is my responsibility to notify Healing Hearts Therapeutic Services, PLLC of any changes to my insurance**, including plan changes, policy number updates, cancellations, or lapses in coverage.
• **I understand that I am financially responsible for all charges** in accordance with my insurance policy, including deductibles, copayments, coinsurance, and any amounts not covered by my insurance plan.
• **If I have secondary insurance, I understand that it is my responsibility to provide any Explanation of Benefits (EOB) that I receive** to Healing Hearts Therapeutic Services, PLLC for billing purposes, and I acknowledge that these documents will be maintained in my (or my child's) clinical chart.
• **I understand that Healing Hearts Therapeutic Services, PLLC is not responsible for denied claims due to cancelled, expired, or inactive insurance coverage.** I assume full legal and financial responsibility for all session fees if my insurance is cancelled, changed, or becomes inactive without prior notification to Healing Hearts Therapeutic Services, PLLC.

CREDIT CARD PAYMENT AUTHORIZATION

Healing Hearts Therapeutic Services, PLLC requires payment for all copays, session fees, outstanding balances, and/or other charges **prior to receiving services**.

By signing this form, you authorize Healing Hearts Therapeutic Services, PLLC to charge the debit or credit card you provide for any balances that accrue on your account. You agree that **no prior notification** will be provided for charges **up to $200 per week** for copays, session fees, and/or outstanding balances.

If your balance exceeds $200, our office will contact you by phone and an invoice will be uploaded into your patient portal.

I authorize Healing Hearts Therapeutic Services, PLLC to charge my credit or debit card weekly for payment of up to **$200** toward my account balance. I understand that I will only receive advance notice if the charge will exceed **$200**.

If the payment method on file is declined and your balance exceeds $200, **your sessions will be paused until payment is made or a new valid payment method is provided.**

By signing below, you acknowledge and agree to these terms.

Healing Hearts Therapeutic Services, PLLC uses Cardpointe through our Electronic Medical Records software, Therapy Notes. All cards processed and stored on Therapy Notes are saved in an encrypted file on the client's portal where you can at any time change the card we will be charging. By signing this notification, you understand that your card information will be stored on file under the client's secure and encrypted medical software and it will be charged for any amounts due at the time of service or you will receive a call from our billing department if you have an outstanding balance or there was an issue with payment.

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Authorization to Pay this Agency

Payment for services to this Agency is due when services are provided. As a courtesy to our clients and families, we will bill your insurance company in accordance with the information you have provided us. It is your responsibility to inform our staff of any changes in your insurance coverage. You are obligated to pay any deductible or co- pay required under your insurance plan, at your time of service.

Fee list

Letters/ Reports for your insurance company or another Agency: **$250.00/ hour**

Court Related costs - letters, testimony, forensic reports, etc.: **$260.00/ hour**

An appearance fee for any subpoenas or court related appearances are subject to an initial $5,000.00 appearance fee in addition to the $2.60.00 per hour for court related costs. This is determined by the clinician and must be paid 7 days before the court date. (Costs for testifying include travel time "door-to-door")

Services not covered by your insurance company: **$250.00/ hour**

(IEP meetings, phone sessions, etc.)

Private pay rates are: **$250.00/hour**

*Sliding scale rates are available upon request and are based on income.

Failure to give 24-hour notice of cancellation of your session will result in a "NO SHOW" charge of $**75.00. Payment must be made prior to rescheduling the appointment.** Please see No Show/Late Cancellation Policy for further information regarding this policy.

NOTE: Medicaid recipients will **not** be charged no show fees.

By electronically signing this document I authorize payment directly to this Agency. I agree to be fully responsible for all lawful debts incurred by myself or my legal dependents listed above for services received from Healing Hearts Therapeutic Services PLLC. I authorize release of any information needed to process claims on my behalf or on behalf of my legal dependent listed in this Registration Packet. I understand that I am responsible for any deductible or co- payment amount as per my insurance coverage on my account. I understand that, although my claims are filed, there is no guarantee of payment for services by the insurance company.

OR

I HEREBY GUARANTEE I HAVE NC STATE MEDICAID AND I AM NOT RESPONSIBLE FOR ANY FEES, EXCEPT APPLICABLE COPAY IF PLAN REQUIRES, NOR WILL I BE CHARGED FOR SERVICES AT ALL.

By Electronically signing this document you understand that fees are due at the time of service, and any card stored on file or processed will be done through our encrypted medical records software and you must notify Healing Hearts Therapeutic Services, PLLC. Of any insurance changes or you will be fully liable for the cost of services rendered. By electronically signing this you attest that you agree and understand this in full and give Healing Hearts Therapeutic Services, PLLC. Permission to bill accordingly for services rendered.