Anxiety and Behavioral Health Services (ABHS)
Psychological Practices: Beth T. McCreary, Ph.D., LLC, Joseph P. DeCola, Ph.D., LLC,
& Associated Independently Contracted Practitioners
6797 N. High Street, Suite 214
Worthington, Ohio 43085
(614) 436 – 5030

Informed Consent for Billing

Name of Client Receiving Services: _____

Date of Birth of Client Receiving Services: _____

Name of Person Responsible for Payment (PRP): _____

Relationship of PRP to Client: _____

Address of PRP: _____

Phone Number of PRP: _____ Email address of PRP: _____

Please read this consent form carefully, as it describes the ABHS billing policies.

Insurance:

All ABHS clinicians are "in-network" with some insurance contracts and "out-of-network" with others. When we are in-network with your insurance plan, we will bill the company, wait for them to process the claim, and then bill you for any "patient-portion" due. Please be aware that many insurance plans today have high deductibles; it is your responsibility to be aware of your deductible and to pay it. When we are out-of-network, we will bill you in full according to the fees listed below, and once we have received payment from you, we will either submit the claim to insurance on your behalf so that you can receive any out-of-network reimbursement due to you from your insurance company, or we will provide you with documentation to submit the claim yourself (depending upon the particular insurance company).

Unfortunately, insurance is complicated. Sometimes when we initially appear to be in-network with the name of the insurance on your insurance card, we learn subsequently that we were actually out-of-network with a "third party administrator" associated with your particular plan (for example), and insurance does not cover your sessions. We do try to verify your insurance coverage prior to seeing you, and in most cases we are able to obtain an accurate answer. However, even after we have done this, we have had situations occur when the claim has been denied for various reasons. ***Ultimately, if you want to use your insurance to pay for services, it is your responsibility to verify with your insurance company that we are included as providers in your plan.*** We strongly encourage you to verify this for yourself, by calling your insurance company and/or searching for the name of your clinician online in your provider directory, in addition to the effort that we make to verify it on our end. ***Should your insurance company refuse to remit payment for our services, for any reason, the person responsible for payment (PRP) agrees (by signing below) to be held responsible for paying the amount in full.***

Secondary insurance. With rare exception (i.e., one clinician in our practice who does some Medicare billing), we will not bill your secondary insurance company for you. You are responsible for paying the practice for anything your primary insurance does not cover, and we will provide documentation for you to submit to your secondary company yourself for any reimbursement due to you. This is true whether or not we are in-network with your secondary company.

Fees:

You will receive an invoice for services approximately weekly for out-of-network services, and approximately monthly for in-network services. Cash, checks, and credit cards are accepted. If you choose to use a credit card for payment, you are accepting the responsibility for the credit card company learning that you are receiving services from one of the therapists in this practice, and for anyone else who sees your credit card bill learning this, as well. If you do not pay your bill within 30 days of the date of an invoice, 2% interest may be added per month to the balance; in addition, if you default on your bill you may be held responsible for collection charges and/or attorneys' fees. The following fees are charged for services:

Assessment (Intake) Session(s) = $300.
Therapy Session (approximately 45 minutes) = $160.
Therapy Session (approximately 60 minutes) = $250.

Phone calls may be billed directly to you, as insurance companies typically do not cover them (with some exceptions during the pandemic). There is no charge for occasional, necessary phone calls (for example, regarding scheduling) lasting under 10 minutes. Calls lasting between 10-19 minutes are billed at $50; 20-29 minutes $90; 30-39 minutes at $125; 40-50 minutes at $160. In the event that a call lasts over 50 minutes, an additional $30 is charged for each additional 10-minute period.

In addition, there are out-of-pocket fees for writing treatment summary reports (for example, if you need a report sent to a psychiatrist or physician) and for reviewing records sent from other professionals. Insurance typically will not pay for these services, although they can require considerable time and effort on the part of the therapist. The fee for writing treatment reports is $150 per hour, and for reviewing records sent from other professionals the fee is $75 per hour.

ABHS will update these fees periodically and will inform you of the changes.

Cancellation policy:

You will be billed a flat fee of $80.00 if you miss an appointment without providing at least 24 hours notice. Insurance will not be billed; this is charged to you. After the third such instance, regardless of circumstances and even if you have paid the fees, your therapist reserves the right to terminate therapy and refer you elsewhere (as the lost time and income becomes significant and others are waiting for appointments).

To the CLIENT: Please sign and date *one* of the lines below with respect to how you will pay for services. If you have another person (besides yourself) sign as the Person Responsible for Payment at the bottom of this form, you are giving us your permission to disclose any information needed for billing, such as appointments kept or missed, fees, & procedural and diagnostic codes appearing on claims, to that person:

_____ (signature / date) I authorize release of information about me as necessary to my insurance company for billing purposes and I authorize payment directly from my insurance company to this behavioral healthcare practice. I understand that I am (or my PRP is) responsible for payment of any balance or co-pay not covered, for any reason, by my insurance.

_____ (signature / date) I do NOT authorize release of any information about me or my treatment to an insurance company. I (or my PRP) will be responsible to pay all fees for treatment.

To the PERSON RESPONSIBLE FOR PAYMENT (PRP, Who may or may not be the Client):
By signing and dating below, you acknowledge understanding and agreeing to all terms above.

_____ _____
Signature of Person Responsible for Payment (Could Be the Client) Date