# PAYMENT POLICY

*Please note: Crossroads Counseling Centers, Inc. may also be referred as: Crossroads and/or CCC*

1. **Insurance.** We accept a variety of insurances, which vary depending on the individual provider. If you have questions about the insurance you are enrolled in and whether or not your plan will cover mental/behavioral health services, please contact your health insurance company directly. We expect you to provide us with a copy of your insurance card prior to services being rendered in order to verify your health insurance coverage.
2. **Co-Payments, Deductibles, and/or Co-Insurance.** Co-payments may or may not be listed on your medical card and are due before services are rendered, *no exceptions*. Deductibles and/or co-insurance are the client's responsibility after your insurance company/companies have processed the claim(s). We will mail a statement with a due date after we've received the explanation of benefits from your health insurance company/companies. It is your responsibility to make your payment in full and on time.
3. **Non-payment.** If CCC does not receive your payment by the due date listed on the statement, you will incur the following late fees:
   **a)** 0-30 days: $15.00 fee **b)** 31-60 days: $30.00 fee **c)** 61-90 days: $45.00 fee
   **d)** 91 days and beyond: You will receive a final statement and letter stating you have 10 business days to make your payment in full. Partial payments will not be accepted unless otherwise negotiated. If your balance remains unpaid, your bill will be submitted to a debt collector.
4. **Non-covered services.** If your insurance does not cover the services provided, or is not considered medically necessary, you will be billed for these services and you must pay for these services in full at the time of visit.
5. **Proof of insurance.** Each client is required to complete our intake information upon their first visit. We require you to provide your insurance card at this time. Paper/electronic copies will not be accepted. If we do not receive this information, you will be billed for the balance.
6. **Claims Submission.** If you provided us with insurance coverage, we will submit the claims to your insurance company on your behalf. It is our intention to process your claims correctly and in accordance to your insurance company's policies. If we receive information that you need to contact your insurance company in order for them to process your claim, it is your obligation and duty to comply with their request. If you fail to follow up on the request, we will send you a bill for the balance. We are an outside party of your health insurance contract; and the contract is only between the insured and the insurance company.
7. **Coverage Changes.** If your insurance changes or there is a change how your services are being covered, notify us before your next visit. If your insurance coverage lapses, and there is no communication after 30 days, we will automatically bill you for the sessions you attended without coverage.
8. **Missed Appointments and Late Cancellation Policy.** It is our mission to serve you during your therapy sessions and we do our best to accommodate your schedule. With the exception of illness and inclement weather, **we require a 24-hour notice if you are unable to attend your scheduled appointment**. Insurance companies do not pay for no-shows or late cancellations. Our policy is to charge you for missed appointments and late cancellations. **You will be charged for no-shows and late cancellations.** These charges are your responsibility and you will be billed directly. After three no-shows or late cancellations, you will not be allowed to schedule another appointment. If you have arranged with your therapist to have standing appointments, all appointments will be removed from the schedule after the first no-show and you will need to arrange appointments on a week-by-week basis. Your therapy is important to us and providing adequate notice when you cannot attend is key to keeping your regularly scheduled appointments.

**We are committed to providing you with the best treatment possible. Please contact our business office with any inquiries regarding the payment policy.**

***I have read and understand the payment policy and agree to abide by its guidelines:***

**Signature:** _____ **Date:** _____

Crossroads Counseling Centers, Inc. reserves the right to change and/or modify the information on this policy at any time.