SELF PAY AND BCBS CLIENTS

COPAYS, CANCELLATIONS & NO SHOW/NO CALL POLICY:

Please be advised that your credit card below will be charged for copays or underpayments for your appointments as applicable. Cancellations and re-scheduled sessions will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, please be aware that you may lose some of that session time.

Please remember to cancel or reschedule 24 hours in advance of your scheduled appointment. You will be responsible for the entire cost of the session (we cannot file insurance if you do not attend a session and therefore we will charge you for the full amount that insurance allows for a therapy session, for BCBS this would be $100 for your initial session, or $87 for individual or family session, for self-pay it would be $160 for the initial session, and $120 for individual or family sessions.) if cancellation is less than 24 hours of the scheduled session. You will be charged the full amount of the session for a NO SHOW to your appointment.

For Copays, you are authorizing Coastal Haven Counseling, LLC to charge this credit/debit or HSA card after each of your sessions going forward for as long as you continue therapy appointments with Coastal Haven Counseling, LLC, or if your insurance company does not cover or pay for your claims, unless an alternative form of payment is made at the time of appointment. For BCBS clients this amount would be a maximum of $100 for your initial intake session, and $87 for individual sessions, minus any amount that your insurance does cover of these costs. For self-pay clients, your initial session is $160 and each session thereafter is $120, and you are agreeing to this charge each time you attend a counseling session to be billed to your credit/debit/HSA card below, unless an alternative form of payment is made at the time of appointment.

Client Name: _____ CARDHOLDER NAME: _____

Cardholder Address: _____

Credit Card Info: *(For Self-pay and BCBS Clients ONLY, NOT with Medicaid/Medicare clients)*

Card Number: _____ Exp Date: _____

3 Digit Security Code: _____ Billing Zip Code: _____

Your signature or e-signature confirms your understanding and agreement to our policy above. Thank you.

Print name: _____

Signature: _____ Date: _____

OFFICE ONLY: Entered into system by: _____