The Neurofeedback Clinic of Northern Colorado

Neurofeedback Clinic of Northern Colorado
4115 Boardwalk Drive, Ste 100
Fort Collins, CO 80525
P970-493-4580

AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

Appointment scheduling:
We ask your cooperation in maintaining a schedule and keeping appointments. We may not be able to schedule a regular appointment time. If a regular appointment time is of interest to you, we will make every effort to ensure that happens. New appointments are scheduled after each session. Sessions can be scheduled as frequently as twice per day up to once per week. However, the first two sessions must be scheduled within several days of each other for optimal monitoring and baseline acquisition.

Appointment cancellation, late arrival, and no show policy:
We ask that you provide at least **24-hour** notice if you need to cancel an appointment. Other clients may be able to fill a canceled appointment time. You may be charged for the full session fee if we do not receive 24-hour notice of cancellation. If you do not show up for an appointment and fail to notify your therapist beforehand, you will be responsible for the full session fee at your next scheduled appointment. It is important that you allow yourself enough time to arrive on time for your appointment. We require all of the time scheduled to provide the best possible services. If you arrive more than **10 minutes late** for your appointment, we will not be able provide services. The appointment will be treated as a late cancellation and you will be responsible for the full session fee. This applies to **all** self-pay, health insurance and victim compensation clients. Please feel free to inquire about your rate. We recognize there are times when emergencies arise, and we ask your cooperation in notifying us as soon as possible if you have an emergency.

Payment agreement:
Payment in full is expected at the time of service. Payment may be made using cash, check, or credit card. Please note that this is a fee for service institution. **Full fees are due regardless of health insurance benefits, allowable rates, existing insurance contracts, etc.** If you have any questions regarding your payment amount, please contact the office manager or your therapist.

Insurance reimbursements:
We will submit claims to all insurance companies that we are in-network with. Clients with out-of-network insurance companies are responsible for full payment at the time of service and for submitting claim forms to their insurance company. Upon request we will supply clients with the information needed by the insurance company in order to file and process a claim. It is the responsibility of the client to determine what their insurance will cover. By signing this form, you are acknowledging that you are responsible for the fees incurred in treatment in the event the insurance claim is denied.

Release of Information and authorization to pay insurance benefits:
By signing this form, I am giving permission to release any information relating to treatment to any third-party payers or insurance companies that may be required or requested to assist in the processing of claims. I am also giving permission for the payment of any medical benefit, or insurance claim, or victim compensation to be paid directly to the Neurofeedback Clinic of Northern Colorado, should they bill directly for services provided.

By signing this form, I acknowledge my understanding of payment policies and this agreement to pay for professional services.

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Signature of client or guardian of minor child **Date**

_____ _____

Printed name of signer and minor child **Relationship**