FINANCIAL POLICY for JOHN GEREMIA, LCSW-C, LLC

All co-pays are due at the beginning of your therapy session. If you are a self-pay client, the amount of your visit will be collected at the beginning of your session.

It is NOT my responsibility to know your insurance carrier. It is your responsibility to know the co-pays and benefits of your plan. If the insurance information is incorrect, due to your failure to submit current information, it is the client's responsibility to pay for the full payment amount, of the services rendered. **It is your responsibility to notify me of any change in address, phone numbers or any change of insurance with appropriate authorization and/or referral.**

Account balances will be expected in full, unless arrangements have been made. You will be charged an additional $30.00 fee for each returned check. You will be responsible for all unpaid balances, fees, attorney and court costs resulting in debt collection procedures.

APPOINTMENTS: It is your responsibility to know when your appointment is scheduled. You will not receive a reminder phone call for any appointments. **You will be charged $50.00 for any appointment that is not cancelled at least one week prior to your scheduled appointment**. This charge is your responsibility. Insurance companies do not pay for missed appointments. If we are able to reschedule your appointment within the same week, you will not be charged the missed appointment fee.

Notice of Private Practices: My practice is committed to securing the privacy of your Health Information (HIPAA). Accordingly, I have posted this "Notice of Health Information Practices" in the waiting area. I would like your acknowledgement that you have been notified that this practice has such a notice as required with HIPPA regulations. I would also like your acknowledgement of receiving a copy.

Patients Assignment of Benefits: I hereby authorize John Geremia, LCSW-C, LLC to apply for benefits on my behalf for covered services rendered. I request payments are made directly to John Geremia, LCSW-C, LLC. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at anytime in writing. **If you are a self-paying client, no information will be given to your insurance company, without a separate written consent of authorization by you.**

______________________________	______________________________
Client or Authorized Person's Signature	Date
______________________________	______________________________
Relationship to the Client	Witness