Phoenix Behavioral Health Services, LLC

3120 Memorial Drive Two Rivers, WI 54241   (920) 657-1780   FAX (920) 657-1784   www.phoenixbhc.com

PAYMENT AND CREDIT POLICY

I understand that PBHS charges the following fees for professional services.

$190.00 Diagnostic Interview (1st Visit)   **$160.00** Psychotherapy/Family Therapy

$40.00 Group Therapy (1 hour) per Individual

PHD RATES **$220.00** Diagnostic Interview   **$200.00** Psychotherapy/Family Therapy

$180.00 Psychological testing per unit

The responsibility for the payment of all professional charges remains with the patient or responsible party regardless of insurance coverage. If you choose to use your insurance, we do file claims with your insurance companies (primary and secondary), verify your insurance benefits, but we **cannot guarantee payment for services by your insurance provider.** Therefore, **you are responsible for services provided.** If payment from your insurance is not received in 30 days, the account is due and payable in full. ANY CHECKS RETURNED FOR N.S.F WILL BE CHARGED A $35.00 FEE.
Insurance clients are required to make their co-payment (the portion your insurance does not cover) at each visit. This will be collected by the receptionist before the start of you session. **Private pay clients** must pay the entire fee at the time of service unless prior arrangements have been made.

You are responsible to notify us of any change in your insurance coverage, your benefits, and your name, address, and telephone number.

If you need to cancel your appointment, please call us 24 hours in advance. **Failure to call may result in a 50% missed appointment fee.** If we are not available to take your call, you may leave a message with our 24-hour answering service.

PAYMENTS MUST BE CURRENT IN ORDER TO RECEIVE SERVICES.

PATIENT FINANCIAL AGREEMENT

I make this agreement with the knowledge and understanding that I accept full responsibility and liability for any and all charges incurred by me and guarantee timely payment of same.

Patient Name ____________________________

Signature ______________________________   Date ______________________   (

FOR OFFICE USE ONLY

_____ 1. I will pay __________% of the fee at the time of each session.
PBHC will bill my insurance company for professional fees. I understand that, should my insurance company not pay services rendered to me, at least half the fee for services is due during the month in which services are rendered and the balance is due within 60 days of the termination of therapy.

_____ 2. Insurance pays 100%
_____ 3. Private Pay (No Insurance) – I will pay the entire fee at the time of service.
_____ 4. Other arrangement negotiated with business manager: (Fill in Amount and Circle One)
$ ___________ per Visit OR $ ___________ per Month   Other ___________