**Counseling and Psychological Services of the Upstate**

**402 Pendleton Rd. #4**

**Clemson, SC 29631**

**864-633-0210**

**Billing and Scheduling Policies**

(Please initial next to each.)

\_\_\_\_\_\_\_: Claims cannot be filed without information regarding insurance. The client is responsible for providing the requested information as part of the intake paperwork.

\_\_\_\_\_\_\_: Client will be expected to pay for each session at the time it is held. Sessions will last approximately

 53-55 minutes with, generally, one session per week.

\_\_\_\_\_\_\_: Client is responsible for full charge for session (not only copay) if session cancelled less than 48 hours before appointment or if client ‘no shows’ for appointment.

\_\_\_\_\_\_\_: If session is shortened due to client being late or client requesting to end early, client is responsible for difference in cost (out of pocket) if billing code for shorter session is needed (e.g. 90834 vs 90837).

\_\_\_\_\_\_\_: Client is responsible for payment of services in full until coverage is determined by returned insurance claim. This can take from 2 days-6 weeks (or more) depending on the insurance provider and whether or not the client provides the full and correct insurance information.

\_\_\_\_\_\_\_: Other professional services (i.e., report writing, consulting with other professional with your permission,

 preparation of records or treatment summaries, letter writing, telephone conversations lasting longer than 15 minutes, other requested and agreed upon services) are billed as a percentage of the clinical hour. Please know that insurance rarely covers these services and client is responsible for payment in full.

\_\_\_\_\_\_\_: If a client misses an appointment and does not contact Dr. Ruth within 48 hours, future scheduled

 appointments will be cancelled.

\_\_\_\_\_\_\_: If a client misses a session, it is the client’s responsibility to contact Dr. Ruth. Dr. Ruth will make

 attempts, via phone, to contact the client. If two weeks go by without the client contacting CAPSU that client’s file will be closed.

\_\_\_\_\_\_\_: I have had an opportunity to ask and have my questions answered regarding CAPSU billing policies and I understand, acknowledge, and agree to the Billing Policies of CAPSU.

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Printed Name Date of Birth

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Signature Date

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Witnessed By