INSPIRE WELLNESS
Psychological, Educational & Performance Services
266 Harristown Rd, Ste 209, Glen Rock, NJ 07452
201-564-7331 |201-564-7337| info@inspirewellnessnj.com |inspirewellnessnj.com

FINANCIAL SERVICE GUIDELINES

YOU ARE RESPONSIBLE FOR UNDERSTANDING YOUR COVERAGE

Bring your insurance card with you to each office visit. It is your responsibility to be aware of your insurance coverage, including but not limited to policy provisions, deductibles, limitations and authorization requirements. If your plan or insurance coverage changes and /or you are issued a new card, it is your responsibility to notify us immediately. We are not responsible for charges that are denied because we have relied on information that is not current. In the event a claim is denied, you will be personally responsible for your bill and/or any outstanding charges.

INSURANCE COVERAGE

Inspire Wellness is an Out of Network provider. As a courtesy, we attempt to verify that your coverage is active and verify your Out of Network, Mental Health benefits before your first appointment with our office. However, you are responsible for finding out all information regarding your out of network coverage prior to your appointment. You are responsible for satisfying the out of network deductible. The deductible is determined by your individual contract with your insurance carrier. Co-insurance fees are your responsibility. Your insurance company expects co-insurance fees be collected at time of service.

Select insurance companies send reimbursement checks directly to the patient/insured for services rendered by Inspire Wellness. Any reimbursement sent directly to the insured for services rendered by our doctors or clinicians must be remitted to Inspire Wellness within 14 days of receipt. Failure to do so will result in Inspire Wellness charging the credit card on file the reimbursement amount.

SELF PAYS

All patients without valid insurance or without Out of Network coverage on their insurance policy are considered self-pay patients. All self-pay patients are required to pay at the time service is rendered. Please be prepared to make this payment with the front desk personnel at the start of your visit.

CANCELLATION POLICY

The time we set aside for your appointment is important and affects our efforts to efficiently serve all of our patients. If you are unable to keep your appointment you must provide us with notice at least 24 hours in advance of your appointment. Failure to give the required 24-hour notice will result in you being charged a $75.00 cancellation fee. **This fee cannot be billed to your insurance company and will be your direct responsibility.** Please call Inspire Wellness at 201-564-7331 with cancellation.

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PAYMENT POLICY

Inspire Wellness will attempt to verify your Out of Network benefits and submit claims to your insurance carrier directly, as an out-of-network provider. However, it is your responsibility to meet your annual out of network deductible, as well as pay the co-insurance fee at the time of service. All patients without valid insurance or without Out of Network coverage on their insurance policy are considered self- pay patients. All self-pay patients are required to pay at the time service is rendered.

Check Policy:

When you use a check to pay for our services, you authorize us to represent your check to your bank for collection either electronically or by paper draft. In the event your check is retuned for any reason, you understand you will be charged for any additional applicable fees as permitted by law.

Credit Card Policy

Inspire Wellness requires a credit card on file for the select insurance companies who send the reimbursement checks directly to the patient/insured for services rendered by Inspire Wellness. Inspire Wellness requires the insurance reimbursement that is issued by the insurance provider for services rendered by Inspire Wellness be remitted to our office within 14 days of receipt of the check or the credit card on file will be charged.

In addition, Inspire Wellness reserves the right to charge the credit card on file for any applicable deductible or co-insurance fees or if you are not in compliance with the cancellation polices.

If Your Account Becomes Delinquent:

We will do our very best to work with you. Our billing office may contact you by telephone, email and/or by mail. If you do not respond to our attempts to discuss your balance we may refer your account to an outside collection agency. Once your account has left our office for collections, we can no longer communicate with you regarding your balance and you must address your circumstances with the agency. You will also be directly responsible for any additional fees associated with the collection of your balance. You should also be aware that referral of your balance to a collection agent may constitute grounds for your discharge from the practice.

If you have any questions regarding our guidelines please feel free to contact our Billing Department at 201-564-7331.

Your signature below acknowledges that you have read, understood our policies and your responsibility regarding the charges and fees that you have incurred as a result of services that you have received from Inspire Wellness.

Name of Patient _____ Date: _____

Name of Parent/Guardian _____

Signature of Parent/Guardian: _____ Date: _____

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Credit Card Information

Name on Card _____

Credit Card # _____ EXP Date _____ CVV _____

□Visa □MasterCard □American Express □Discover

Please initial:

_____I understand Inspire Wellness reserves the right to charge my credit card for any applicable deductible or co-insurance fees should payment not be made at the time of the appointment.

_____I understand Inspire Wellness reserves the right to charge my credit card if I am not in compliance with the cancellation policy.

_____I understand as a member of an insurance provider that reimburses the insured rather than the provider rendering the service, Inspire Wellness reserves the right to charge my credit card the reimbursement payment issued by the insurance provider if the reimbursement check is not brought to Inspire Wellness within 14 days of receipt of the payment. In the event Inspire Wellness charges my credit card the reimbursement payment, the member can then keep the check issued by the insurance provider.

_____ I understand Inspire Wellness reserves the right to pass on any applicable chargeback fees permitted by law associated with a disputed credit card charge.

_____ I understand failure to comply with our polices may result in termination of services. In addition, Inspire Wellness reserves the right to forward the account to Collections and report the account to a Credit Bureau.

Name of Patient _____ Date: _____

Name of Parent/Guardian _____

Signature of Parent/Guardian: _____ Date: _____

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PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD. Your understanding and cooperation is greatly appreciated.

Client Information

Name _____ Date of Birth _____ □M □F

Address _____

City _____ State _____ Zip Code _____

Cell # _____ Alternate # _____

Email Address _____

Insurance Information

Name of Insured _____ Date of Birth _____ □M □F

Address □Same as Client _____

City _____ State _____ Zip Code _____

Cell # _____ Alternate # _____

Email Address _____

Relationship to Insured □Self □Spouse □Child □Partner □Parent □Other _____

Insurance Company _____

Plan ID # _____ Group # _____

Secondary Insurance: □ Yes □ No | Medicare: □ Yes □ No | Medicaid: □ Yes □ No

Emergency Contact

Name _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Cell # _____ Alternate # _____

Email Address _____

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HIPAA Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in office in print form). I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at anytime at the address(s) below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

_____

Patient's Name & Date of Birth (MM/DD/YYYY)

_____

Signed (Patient or Legal Representative for Patient)

_____

Date

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CLIENT CONSENT TO THERAPY

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I agree to pay the initial evaluation fee and agreed upon session fees. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with _____ I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by _____. I am over the age of eighteen.

Client: _____ Date: _____

Witness: _____ Date:_____

CONSENT FOR TREATMENT OF MINORS

I/we _____ have full custodial guardianship of my child _____. He/she is currently under the age of 18, and I/we consent that he/she may be treated as a client by _____.

Parent or Guardian: _____ Date: _____

Client Assent (if over the age of 14): _____ Date: _____

Witness: _____ Date: _____

Parents: Do not leave the office while your minor child is with his/her therapist. A responsible adult must be present during your child's visit. It may be necessary for the therapist to speak with you at some point during your child's session.

VERIFICATION STATEMENT OF THERAPIST

This document was discussed with the client and questions regarding fees, diagnosis, and treatment plan were discussed. I have assessed the parent's or guardian's mental capacity and found her or him capable of giving an informed consent at this time.

Initial of Therapist _____
Date _____