Monarch Therapeutic Services, LLC

Beverly T Chevalier, LCSW

FINANCIAL POLICY

FOR CLIENT_____

Below are the terms of agreement regarding payment for sessions with **Beverly T Chevalier, LCSW**

1. Session fees are based on a clinical hour, which is defined by insurance providers as 45-50 minutes with the therapist or mental health professional.

2. If I, the client, fail to appear for an appointment without a 24-hour notice of cancellation, appointment fees may be charged and I will be responsible for payment.

3. I understand if I am late to a session, that session will end at the time originally scheduled. It is my responsibility to arrive on time. If I am more than 10 minutes late for my scheduled appointment and did not make arrangements with the therapist, my appointment may be forfeit and I may have to reschedule and appointment fees may be charged.

4. Services including phone calls, emails, record reviews, and professional consultations at times other than the scheduled therapy session are the client's responsibility. These services will be billed per quarter of an hour.

5. I authorize my health insurance to provide payment of benefits to **Beverly T Chevalier, LCSW.**

6. I understand records of my treatment may be shared with **HUSKY and Blue Cross** (and other applicable insurers) when necessary to process claims.

7. I understand that if I am covered under private insurance and HUSKY, ***the private insurance is considered primary and must be billed first.***

8. I understand I am responsible for all payments due if my insurance company declines payment.

9. I understand that I am responsible for any services, deductibles or other out-of-pocket expenses not covered by my insurance company, including a co-payment of $_____ due at the time of service.

10. I understand that I am responsible for informing Monarch Therapeutic Services, LLC of any changes to my insurance, and any payments declined due to change is insurance status are my responsibility and due upon presentation of invoice.

Furthermore, I understand that until my insurance is restored, I am responsible for payment in full for all services provided at the time services are provided.

I have reviewed this document and understand the above statements.

_____ _____

Client/Guardian Signature Date

_____

Printed name

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