Patient Name:_____DOB:_____Date: _____

## Mosaic Family Counseling Center, INC
### Patient Financial Agreement

**Patient Responsibilities:**

- Patients are responsible to provide us with accurate billing information for each family member at the time of service.
- If the patient's insurance company requires them to choose a primary care provider (PCP), it is the patient's responsibility prior to their visit to ensure that they have authorizations for their visits with MOSAIC FAMILY Counseling Center, Inc.
- Our billing staff is available to provide our patients with assistance, but cannot resolve disputes between patient's and their insurance companies.

**Copayments:**

- The patient's insurance company requires them to pay their copay at the time of each visit.
- The patient's copay may be paid via cash, credit/debit card, and/or check.
- If a patient under the age of 18 comes for an office visit without a parent/guarantor copayments are still required at the time of each visit.
- If a check is returned a $25.00 returned check fee will be assessed.
- Patient's who do not have insurance, will be expected to pay at the time of each visit.
- If we cannot verify the patient's insurance(s) coverage at the time of their visit, we require a minimum of 50% deposit per visit.

**Deductibles:**

- It is the patient's responsibility to understand any deductible that may apply to them under their insurance policy.
- Our billing department will send each patient a statement of the amount their insurance company has determined is applied to their deductible and is owe by the patient.

**Payments with Credit/Debit Card:**

- As a part of our company policy, an additional fee will be applied to any payments made by a debit/credit card. Any payments made in-office with a credit/debit card will be charge 2.75% of the total balance. Over-the-phone credit/debit payments will be charged 3.5% of the total balance.

**Insurance Information:**

- It is the patient's responsibility to ensure that we have accurate insurance information. Presenting an invalid or inactive insurance card will result in full payment by the patient or their parent/guarantor.
- Medical insurance does not always cover the entire cost of the patient's medical care. If we believe a service we offer is not covered by the patient's insurance coverage, MFCC will inform the patient. In some instances, however our company does not learn that a service is not covered until after we submit a bill. The patient or parent/guarantor are responsible for payment if the their insurance company refuses to pay for a service(s).


5005 Douglas Avenue, Suite 101
Des Moines, IA 50310
Phone: (515) 724-8920
Fax: (888) 771-3225

2343 US Highway 169
Mount, Ayr, IA 503854
Phone: (641) 781-0082
Fax: (888) 771-3225

531 West Main Street
Lamoni, IA 50140
Phone: (641) 781-0082
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**Home address and Telephone:**

- Patients are asked to complete an electronic patient registration (via initial phone call) that asks for important information about them. Please answer to the best of your knowledge and keep us informed of any changes on subsequent visits.
- It is the patient's responsibility to keep demographic information (Name, address, phone numbers, etc.) as well as insurance information up to date. Please notify MOSAIC FAMILY Counseling Center, Inc. within 30 days of these changes.
- It is important that we have accurate information on the Parent and/or guarantor. This is the person who is financially responsible for the patient.

**Cancellation Policy:**

- 24 Hour notice is expected and appreciated, unless due to an emergency.
- A fee of $10.00 will be charged for a cancellation **less** than 24 hours in advance.
- A fee of $25.00 will be charged of a missed appointment without a cancellation notice **(No Call/No Show)**
- Chronic cancellations/no call, no shows will result in a removal of future appointments from your provider's schedule.
- Insurance cannot be billed for missed appointments and late cancellations.

**Assignment and Release:**

**I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Recent chances in insurance regulations shorted the time frame for claim submissions. I agree to pay any out of pocket expenses in full to MOSAIC FAMILY Counseling Center, Inc. within thirty days from today's date (___/___/___) for uncovered or denied services by my presented insurance coverage.**

_____ _____

**Patient's Name (Printed)** **Staff Signature/Credentials**

_____ _____

**Patient/Guardian/Parent's Signature** **Today's Date**



*Committed and Responsive*

www.mosaicfamilyinc.com *"We all deserve to be happy and feel capable in life"* info@mosaicfamilyinc.com

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