JENNIFER HARRIS PSYD & ASSOCIATES
2000 N. RACINE AVE | SUITE 2190
CHICAGO, IL 60614

Fees, Cancellation Policy, and Credit Card Authorization

Jennifer Harris PsyD & Associates Cancellation/No Show Policy

Effective 1/1/2022

This policy supersedes any and all previous policies regarding the subject matter hereof, including, but not limited to, any temporary policies

It is the policy of Jennifer Harris PsyD & Associates (the "Company") to allow appointments to be cancelled or rescheduled at no charge with at least 24-hour notice.

- **If you cancel an appointment with less than 24-hour notice, or fail to show up, you will be charged a $100 fee for the appointment. Insurance will not cover for missed appointments, so you will be responsible for the full fee.**

- **If you arrive more than 15 minutes late, the session will be treated as a late cancellation and $100 will be charged to the credit or debit card on file. Due to strict time requirements by insurance companies as well as the benefit of having the full session, it is incredibly important for clients to arrive on time. If you know you are going to be late to session, please reach out in advance.**

*In-person appointments may be switched to Telehealth at no charge in the event you would like to still hold session, but prefer not to come into the office due to illness or other conflict.

There are three exceptions to the cancellation policy. The first is that if you email and ask about moving your appointment to a different slot on the same day, *and if the Company is able to comply with your request*, this will be done without any charge to you. The second is in the event that on the day of your appointment, you feel ill and do not believe you can have a productive therapy session. The final exception is in the event of inclement or extreme weather, an early determination will be made whether to remain open for in-person appointments or to switch to a telehealth appointment. If you had an in-person appointment scheduled and do not have the ability to meet virtually, you will not be charged for the appointment.

By signing below, I understand and agree to these terms. I understand the conditions of this policy and agree to the conditions stated above.

PATIENT NAME (PRINT) _____

PATIENT SIGNATURE _____ DATE _____

WITNESS SIGNATURE _____ DATE _____

Jennifer Harris PsyD & Associates Payment Policy

It is the policy of Jennifer Harris PsyD & Associates ("the Company") to provide you with information related to billing processes and your financial responsibilities as a patient.

Insurance: The Company participates in BlueCross BlueShield PPO and Blue Choice plans as well as United Healthcare PPO plans. If you are insured by an insurance plan that the Company does not participate in, payment is due in full at the time of session. Knowledge of your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage and benefit information.

Proof of Insurance: All patients must complete the patient information forms prior to receiving services. A copy of your driver's license or other picture identification and a copy of your current valid insurance card, which will provide proof of insurance is required prior to receiving services.

Claim Submission: The Company will submit your claims for you to your insurance company and within reason, attempt to help you get your claims paid. Your insurance plan may need you to supply certain information directly. It is your responsibility to comply with their request.

Coverage Changes: Insurance companies have very strict requirements regarding filing deadlines for reimbursement of claims. Please notify the Company immediately of any insurance changes. If a claim is denied due to a change in insurance, this balance will be transferred to you.

Copayments, co-insurances, and deductibles: The Company will do their best to obtain an accurate quote of patient responsibility at the time of service. This quote is only an estimate and the Company cannot guarantee its accuracy, but will let you know if anything is different when your claims process. This estimated quote of patient responsibility is due at the time of services. This arrangement is part of your agreement with your insurance company. If there is a patient responsibility balance due after a claim has been submitted, this amount will be billed to your credit card on file. Statements of payments can be provided to you upon request.

Types of payment accepted: The Company accepts cash, check, and most credit cards and HAS cards via Simple Practice's secure and HIPAA-compliant Simple Practice portal. The Company requires that a credit card be saved on file to be charged the applicable fee in the event of a late cancellation/no show, or outstanding balance.

Self-pay patients: Patients with medical insurance coverage that the Company is not paneled with and self-pay patients are responsible for any and all charges that result from professional services provided by the Company. Payment is due in full at the time of session, unless other payment arrangements have been approved. The hourly fee is $200 for the initial intake session and $180 for follow-up sessions.

Balances: If a patient has accrued a balance of more than $500, this must be paid prior to scheduling or holding any further sessions.

Collections: The Company reserves the right to consider delinquent patient accounts for external collection efforts in accordance with state and federal regulations.

Legal Proceedings: If a patient becomes involved in legal proceedings that require the participation of any therapists at The Company, the patient will be required to pay for any professional time spent on their legal matters, even if the request comes from another party. The legal fee is $200 per hour for professional service the therapist is asked/required to perform in relation to the legal matter. The patient will also be charged a copying fee of $0.30 per page for records.

By signing below, I understand and agree to these terms. I understand the conditions of this policy and agree to the conditions stated above.

PATIENT NAME (PRINT) _____

PATIENT SIGNATURE _____ DATE _____

WITNESS SIGNATURE _____ DATE _____

Jennifer Harris PsyD & Associates Credit/Debit/HSA Card Authorization Form

Please note that this form and your credit card information will be securely stored on an online portal that is password protected for your safety. While all secure methods to protect your information are in place, and your safety is taken seriously, no company can 100% guarantee that any online system cannot be breached, thus you are accepting responsibility and risk in allowing Jennifer Harris PsyD & Associates (the "Company") to store your information for therapy charges.

I authorize the Company to keep my card information on the Simple Practice online portal that is password protected and charge my credit/debit/HSA card for professional services as follows:

- Late cancellation/ no-show fees
- All sessions, or insurance cost of patient responsibility (i.e. copays, coinsurance, deductibles), in the next 12 months (after each session).
- Any unpaid balance, including balance of my account after insurance has been billed.

I understand that this authorization is valid until canceled in writing. Additionally, I agree that the card listed below may be charged by the Company in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services.

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact the Company for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with the Company and those attempts have failed.

PATIENT NAME (PRINT) _____

PATIENT SIGNATURE _____ DATE _____

WITNESS SIGNATURE _____ DATE _____