Abella Psychotherapy & Consulting, LLC

OFFICE POLICY

_____ I hereby authorize and assign my insurance carrier to make payment directly to Abella Psychotherapy & Consulting for insurance benefits for services herein specified and otherwise payable to the insured.

_____I understand and agree that **I am financially responsible** to Abella Psychotherapy & Consulting for **all charges incurred** regardless of potential insurance benefits, including but not limited to copayments, co-insurance, deductibles, and non-covered services.

_____I understand that payment is due at the beginning of **every** treatment session. Payment can be made in the form of exact cash amount; check; Venmo; PayPal; or debit/cred/HSA card. I understand and agree that, due to COVID safety protocol, I am **REQUIRED** to keep a credit card on file with Abella Psychotherapy. I will be informed of my credit card being processed **prior** to payment and will receive an emailed receipt of these transactions via Quickbooks. If payment cannot be made or credit card on file is declined, Dr. Abella will cancel any upcoming sessions until payment is made.

_____I understand that Abella Psychotherapy will not become involved in disputes between the patient and the insurance company. I understand that **it is my responsibility** to verify with my insurance company that Dr. Michelle Abella is covered under by insurance, and to obtain all required referrals or authorizations for services as deemed necessary by my insurance carrier.

_____I understand that if Abella Psychotherapy receives a returned check, I will be charged an additional $50 above the amount on the check and will be seen on a cash only basis thereafter.

_____I understand that I **MUST give at least 48 hours notice** if I am needing to reschedule or am unable to keep an appointment. If I am physically ill or a dependent is sick, I need to give 24 hours notice if possible. Failure to do so will result in a charge of **$100** and is not covered by insurance. Dr Abella will provide all appointment reminders and office communication via email, phone, or text.

_____I understand that, after 2 No Shows, 2 Late Cancels, or any other non-compliance issue, Dr. Abella reserves the right to discharge me from her practice. If this occurs, records will be released to a treatment provider of my choice only when a signed release of information is received by this office.

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Patient Signature (parent or guardian signature if needed) Date