**CONTRACT FOR PAYMENT OF SERVICES**

I understand that I am assuming responsibility for payment of my/legal dependent/minor child’s legal bill at the time of the session, unless other arrangements are made and herein specified. I also understand that should the client account balance remain outstanding, that The Attachment and Trauma Center of Nebraska (ATCN) utilizes the services of a collection agency and I agree that ATCN may release my name to any necessary party in the course of obtaining payment.

**Self-pay fees and insurance co-pays are expected at the time of service and should be made available at the beginning of each session.**

\_\_\_\_\_ *Option A*: I/We wish to self-pay and NOT use any insurance benefits. I/We do not give permission for any confidential information about me (or my partner) and my/our treatment to be released to any third party payer, employer, or insurance company. Self-payments may be made from a HSA or FSA account via check or credit card.

\_\_\_\_\_ *Option B*: I/We wish to use insurance to help pay for services.

\_\_\_\_\_ A copy of my insurance card is included for billing purposes \_\_\_\_\_\_\_ (initial)

For clients choosing to use health insurance for treatment, it is the client’s responsibility to ensure you have current mental health benefits for outpatient office visits. Insurance companies only quote benefits and do not guarantee payment over the phone. Any disagreement regarding payment of a claim by insurance is between the client and his/her insurance company. **Ultimately, payment of the bill is the client’s responsibility.**

Name of Primary Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber (Policy Holder) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Secondary Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber (Policy Holder) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have spoken to my insurance company and confirmed that I have current mental health benefits for outpatient office visits and my insurance co-pay is $ \_\_\_\_\_\_\_\_\_\_\_\_ per office visit and/or my co-insurance is \_\_\_\_\_\_\_\_\_\_\_\_\_\_%.

My insurance company requires pre-authorization: \_\_Yes \_\_No, if yes, the authorization # is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I believe I have already met my insurance deductible for this year: \_\_Yes \_\_No.

If not, the remaining deductible is: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as of \_\_\_\_\_\_\_\_\_\_\_\_\_ (date).

If benefits are unknown, a nominal charge of $\_\_\_\_\_\_\_\_\_\_\_ may be collected at each session. This amount collected will be credited toward your balance due.

638 N. 109th Plaza \* Omaha, NE 68154 \* Bus. Office 402.403.0190 \* Fax 402.932.4121

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**CONTRACT FOR PAYMENT OF SERVICES Page 2**

**Assignment of Insurance Benefits**

Signature on this contract authorizes payment of medical benefits to The Attachment and Trauma Center of Nebraska, LLC. (ATCN) for services rendered (assignment of benefits). I understand my insurance company (if applicable) may be billed the full amount for the session and that aside from my co-pay (if applicable), and providing that ATCN is considered “in-network” for my insurance plan, I am not liable for any difference between the billed amount and the reimbursement amount previously contracted between the insurer and ATCN.

I/we the undersigned acknowledge that my/our insurance company may request clinical information, including diagnosis, prognosis, and treatment plans and hereby authorize the release of any appropriate information relating to payment of claims submitted to insurance on behalf of myself/us and/or dependents. I/we further expressly agree and acknowledge that signature of this document authorizes ATCN to submit claims for insurance benefits, for services rendered, or for services to be rendered, including treatment plans, without obtaining my/our signature to each and every claim submitted for myself/us and/or dependents and that I/we will be bound by this signature as though the undersigned had personally signed the particular claim. I/we therefore authorize the insurance company to pay and hereby assign directly to ATCN all insurance benefits, if any, otherwise payable to me/us for services described on the attached forms. I /we understand that I/we are financially responsible for all charges incurred, whether or not paid by insurance. I/we further acknowledge that any insurance benefits, when received by and paid to ATCN, will be credited to my/our account, in accordance with the above said statement.

**I understand that it is important that I provide at least 24-hours’ notice of cancellation of a scheduled appointment, and in not doing so, I will be liable for a charge of $60.00 for this scheduled time. This charge will be the responsibility of the client.**

It is usual practice, and preferable, to provide payment for the session (or insurance co-pay, if applicable) at the start of each session by cash, check, or credit card.

\_\_\_\_\_\_\_\_ (initial) If preferred, and at your request, your credit card information may be maintained in your secure, encrypted EHR (electronic health record) for future co-payments due.

**\_\_\_\_\_\_\_** (initial) **I further understand that I will be charged $35 for any returned form of payment.**

Card holder’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I/we acknowledge understanding of and agree to the terms of this contract for payment of services:

Client/Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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