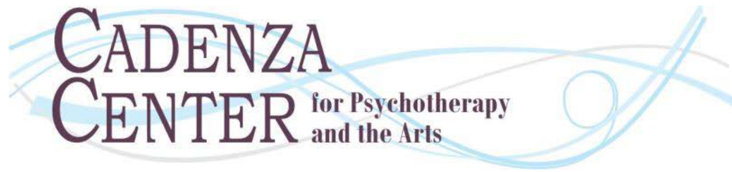

450 N Park Rd. Suite 400
Hollywood, FL 33021
Phone: 954-925-3191
Fax: 954-925-3193
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Financial Responsibility Agreement

Client Name: ____________________________________ Responsible Party Social Security Number ______-______-______

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. For your convenience, we accept Visa, Mastercard, cash, money orders or checks. Non-payment of fees may result in the interruption of your services.

I understand that I am responsible to meet my insurance deductible and make co-payments as required by my plan in addition to any services provided that are not covered by my insurance carrier. The Cadenza Center strives to obtain accurate insurance information; however, sometimes the information may be inaccurate. I also understand that payment by an insurance company cannot be guaranteed. **I understand that I am responsible for prompt payment (within 2 weeks of written notice) for these services received when my insurance carrier refuses to make payment against claims made (regardless of reason – i.e., deductible, inaccurate copay information, inaccurate number of sessions approved).** I am entitled to a detailed description of the charges in dispute. I agree to submit to the Cadenza Center any payments I directly from my insurance carrier for services performed on my behalf.

I understand that in order to receive the best clinical services, my therapist may be available for brief phone sessions to speak with me or other professionals involved in my care when necessary. I understand that these services and time are not billable to my insurance carrier and therefore **I am responsible for payment for services lasting more than 15 minutes**. I understand that I will be billed a **pro-rated fee** for these services based upon my therapist's customary session fee. My therapist or office staff will advise me of any fees applied to my account. In addition, I agree to pay any fees assessed when I request completion of forms, preparation of letters, treatment summaries, etc.

Insurance carriers do not provide reimbursement for cancelled or missed sessions. **I understand that unless my session is canceled with at least 24 hours in advance, I may be charged for the missed appointments.** Exceptions will be made for emergencies or other extraordinary/unexpected circumstances. These fees are as follows:

Type of Appointment & duration	Non-Cancelation/ No Show Fee
ABA services: late arrival/early dismissal more than 25 minutes from scheduled session	$40
Mental health / therapy appointments; individual and group (45-60 minutes)	Typical FULL self-pay rate; (max $150)
Appointments lasting up to 3 hours (testing, ABA, etc.)	$150
Appointments lasting 3 or more hours	$300

My therapist/BCBA may make exceptions and waive the fee, at his/her discretion. Two or more consecutive missed appointments or inconsistent attendance may result in termination of therapy.

The Cadenza Center reserves the right to refer any unpaid balance to an outside collection agency and to take appropriate legal action to collect unpaid balances. I know that I will be responsible for payment of all fees and costs associated with these collection efforts, including payment of any court costs and attorney's fees. **I understand that unpaid balances greater than 30 days may be subject to a late fee of the greater of $25 or 2% of the outstanding balance. I agree to pay a $1.50 statement fee for outstanding balances carried past 60 days.**

A photocopy of this authorization is as valid as if it were an original executed document. I authorize the release of payments and medical information necessary to process my and/or my family members' insurance claims and related claims. I hereby authorize payment directly to my therapist or to Cadenza Center for Psychotherapy and the Arts, Inc. of the insurance benefits otherwise payable to me for all professional services received.

I have read the financial policy and had an opportunity to have question answered. I understand and voluntarily agree to this financial policy.

Name of Client/Guardian: ____________________________________ Date: ___/___/___

Signature: ____________________________________ Date: ___/___/___