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Assignment of Benefits Financial Responsibility and Telehealth Consent

R.A.N. Counseling PLLC

Assignment of Benefits / Financial Responsibility/Telehealth Consent

I acknowledge the payment and insurance information set forth below and agree to pay for services rendered to me and/or facilitate the payment for services rendered to me by the providers affiliated with R.A.N. Counseling PLLC (Practice)

1. Payment of Fees: I agree to pay for charges for services as described in this agreement. I understand that:

- Payment for sessions with providers affiliated with Practice is payable online through debit or credit card or ACH transfer, unless otherwise established. I agree that my credit card can be charged for any session that is not cancelled at least 48 hours prior to the scheduled session.
- I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form.
- I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify R.A.N. Counseling PLLC in writing of any changes in my account information or termination of this authorization. I acknowledge that credit card transactions could be linked to Protected Health Information.
- Payment for sessions is due after each session unless otherwise agreed upon and Practice will charge my card or bank account for my responsibility. Receipts may be provided at the time of the charge or monthly.
- I will be charged for sessions that I do not keep, unless I provide a 48 hour notice to the Practice.
- I understand that I cannot submit bills for cancellations to my insurance company or managed care plan

2. Insurance and Managed Care Plans:

Practice participates in a number of insurance and managed care plans. If Practice participates in my plan, I agree to pay all applicable deductibles, co-payments, co-insurances and any other form of cost-sharing. If my insurance benefits run out, I will be responsible for all charges dating from the end of insurance coverage. Practice Private Pay rate is $130 for a 45-60 minute follow-up session, and $150 for a 60-minute intake session. If my insurance plan denies the visit despite Practice following necessary procedures, I understand I may be responsible to pay in full for the service. Clients should inform the therapist of any changes in insurance immediately.

Insurance coverage varies widely between plans, and it is the client's responsibility to contact their insurance provider directly to confirm eligibility, network status, benefits, deductibles, copayments, and any limitations on coverage for behavioral health services. The Practice does not verify or guarantee whether services will be covered under your specific insurance plan or whether the provider is considered in-network with your plan.

Submission of a claim does not guarantee payment by the insurance company. If a claim is denied, applied to your deductible, or otherwise not paid by the insurer for any reason, and the Practice has submitted the claim according to standard billing procedures, the client agrees to be financially responsible for the full cost of services.

Payment for services remains the client's responsibility regardless of insurance reimbursement.

3. Assignment of Insurance Fees; Release of confidentiality for authorization of benefits and for clinical care:

I agree to allow my insurance plan or managed care plan to pay Practice directly, instead of paying me. In the event that my plan pays me directly, I will promptly turn the payment over to Practice unless I have already paid the charges myself. I authorize Practice to provide my insurance plan or managed care plan any information reasonably required to obtain insurance benefits and authorization for services. I authorize Practice to obtain at any time during my treatment here, any and all relevant clinical information from clinicians and facilities that have treated me and to furnish relevant clinical information to providers who will continue to treat me. I will indicate in writing any exceptions to this.

☐ Agreement & Signature

Date (YYYY-MM-DD)