The Saluda Counseling Center
2400 West Main Street
Rock Hill, SC 29732

FINANCIAL STATEMENT OF UNDERSTANDING

- Initial _____ Payment is expected on the day of your appointment. Your insurance contract requires that we collect your copay for services. A $15.00 fee will be charged if payment is not made on the date of service
- Initial_____ All balances should be paid within 20 days of the date of service
- Initial_____ Missed Appointment Fee: We require at least 24 hours' notice to cancel an appointment. We provide a 24 hour live answering service, courtesy confirmation calls, and can take your call during business hours. If we are not notified of your missed appointment:
    - You will be responsible for the missed appointment fee
        - $45.00 for a therapy appointment
        - $50.00 for a medical appointment
    - You will not be rescheduled until the fee for the missed appointment is paid.
    - We cannot bill your insurance for the missed appointment fee.
- Initial_____ You are required to keep three consecutive visits with your provider before we are able to complete any FMLA, or Disability forms. Please review our Disability Form Fee Notice if you have a request. Fees for these forms can range from $25.00 - $75.00 and must be paid prior to the forms being reviewed and completed.
- Initial_____ There is a $45.00 fee for returned checks. If not paid in full within 10 days your account will be turned over to the Worthless Check Unit in Rock Hill, which will result in additional fees.
- Initial_____ Requests for medical records are charged a base fee of $15.00. If records are provided to include greater than 30 pages, an additional $ .65 per page is charged. If records are provided to exceed 50 pages, an additional $.50 per page is charged.
- Initial_____ Upon request prescriptions can be mailed, a $15.00 fee will be required prior to mailing.
- Initial_____ It is your responsibility to meet all requirements for EAP Authorizations as set forth in your EAP contract.
- Initial_____ It's your responsibility to provide correct insurance information at the time of service. If incorrect information results in insurance denial, balances will be your responsibility.

I understand the above statement of fees and policies.

_____ _____

Patient/Authorized Person Signature Date

_____

Authorized Person Relationship to Patient *(if applicable)*

_____ _____

Witness Date

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2400 West Main Street
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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Concerning the use of my personal medical information, I ALLOW the following family members and/or friends as written below on my behalf:

1) _____

Print Full Name of Person

- ☐ to schedule/reschedule/cancel appointments
- ☐ to pick up written prescriptions or samples
- ☐ to discuss billing information
- ☐ to discuss insurance information

2) _____

Print Full Name of Person

- ☐ to schedule/reschedule/cancel appointments
- ☐ to pick up written prescriptions or samples
- ☐ to discuss billing information
- ☐ to discuss insurance information

3) _____

Print Full Name of Person

- ☐ to schedule/reschedule/cancel appointments
- ☐ to pick up written prescriptions or samples
- ☐ to discuss billing information
- ☐ to discuss insurance information

- Initial_____ I have been presented with a copy of The Saluda Counseling Center's Notice of Privacy Practices, I understand this notice and that my information may be used only as permitted under federal and state law.

_____ _____

Patient/Authorized Person Signature Date

_____ _____

Printed Name Authorized Person Relationship to Patient (*if applicable)*

_____ _____

Witness Signature Date