FINANCIAL RESPONSIBILITY FORM

Client's Name: _____

Therapist Name: _____

Payment Options

Insurance: Your insurance policy is a contract between your insurance company and yourself; Akron Family Institute (AFI) is not a party to that contract. It is your responsibility to understand whether therapeutic services are covered, including your portion of the financial responsibility for said services. AFI cannot guarantee payment of your claims, and we do not accept responsibility for negotiating claims with your insurance companies or other persons on your behalf. You are responsible for payment of your (or your minor's) services in the event that your insurance company pays only a portion of your bill or rejects the claim(s). Thus, any portion of your bill not covered by your insurance is to be paid by you, and the balance is expected to be paid in full**.** We will provide supporting documentation at your request to assist you in appealing your rejected claims.

If you wish to utilize your insurance policy to pay for your services, you are required to provide insurance information prior to your initial appointment. AFI will subsequently bill your insurance for services rendered. Please note that you are responsible for providing updated insurance information to AFI yearly and/or in the event that you make any changes to your policy and/or plan. If an insurance claim is denied due to AFI having inaccurate and/or out-of-date insurance information, you are required to pay the balance in full.

Self-Pay: You may elect not to utilize your insurance to pay for services at AFI. In that case, you and your therapist will negotiate an out-of-pocket rate you will pay per session, and your insurance will NOT be billed. You assume responsibility for paying all charges on your account. A separate "Self-Pay" form may be completed with your therapist in order to outline the agreed-upon rate per session.

Regardless of your payment method, you are responsible to **pay co-payments, co-insurance, deductibles, and out-of-pocket (self-pay rate) **at the conclusion of your session**. If receiving teletherapy, you may make a payment through the AFI website or call the office to provide payment information over the phone.

Should you encounter financial hardship, please contact the office to set up a payment plan to remedy your balance. AFI reserves the right to send your account to collections after 90 days of non-payment on your account.

No Show & Late Cancellation Policy

It is AFI's policy to charge $80 for any appointments missed and/or canceled within less than 24 hours notice. These fees cannot be billed to your insurance, and you are responsible to pay them.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER COVERED BY INSURANCE OR NOT. I AUTHORIZE THE THERAPIST AND AFI STAFF ON BEHALF OF THE THERAPIST TO RELEASE ALL MEDICAL INFORMATION NECESSARY FOR TREATMENT, TO SECURE PAYMENT OR HEALTH CARE OPERATIONS.

Print Name of Person Responsible for Account: _____

X _____ _____

Signature of Person Responsible for Account Date

I AUTHORIZE THE ASSIGNMENT OF INSURANCE BENEFITS TO AKRON FAMILY INSTITUTE, INC.

X _____ _____

Signature of Person Responsible for Account Date

A $25.00 FEE IS CHARGED ON ALL RETURNED CHECKS.