Financial Policy

Ivy Collaborative Healthcare

Thank you for choosing Ivy Collaborative Healthcare for your health care needs. We are committed to providing you with the best possible care and to your treatment being successful. To achieve this outcome, we must emphasize that our relationship is with you, not your insurance company, as your mental health provider. We will bill your insurance company as a courtesy if you are covered under certain participating insurances. **It is the patient/guardian's responsibility to contact the insurance company to ensure that your clinician participates in your plan and answers any questions concerning your coverage. It is also your responsibility to understand your coverage and benefits.** We are not responsible for knowing the requirements of your specific plan. We will try to assist you to ensure that all plan requirements are met. Ultimately, the patient/guardian, is financially responsible for any services provided by our office that are not covered by your plan. This Financial Policy supplements and does not replace the Privia Medical Group Financial Policy.

Please make a note of the following items:

- At the time of service, proof of current and valid insurance must be provided. If you are unable or do not provide this information, you will be considered a self-pay patient. You will then be required to pay the full charge before being seen.
- Your co-payment and any deductibles and balances which may apply will be collected when you check-in.
- We suggest that a credit card be kept on file for late cancellation fees. We accept CASH or CREDIT CARD (American Express, Visa, MasterCard, Discover). Please bring exact change as the office does not carry cash.
- We are happy to file claims to your health insurance, but will not file automobile, general liability, homeowner's or workman's compensation insurance.
- If you have HMO/POS insurance, it is your responsibility to obtain a referral number from your primary care provider (PCP) before being seen by our providers. If you fail to obtain this information, the bill will be your responsibility and you will be required to pay the full charge prior to being seen.
- Failure to receive your statement does not relieve you of your financial obligations.
- It is your responsibility to notify the office with any changes to your personal contact and/or billing information.
- There will be charges for services provided outside of individual appointments (e.g. lengthy telephone calls made by the clinician, provider fee forms, etc.)
- Past due accounts are subject to our collections process and dismissal as a patient from our clinic.
- A fee will be charged for the completion of forms, letters.
- A $50 fee will be charged for Non-Sufficient Funds (NSF) checks in addition to any fees from your bank.

Please understand that payment of your bill is considered part of your treatment. I have read and understand the above billing/payment policy. My signature denotes that I agree to pay for services under the conditions and specifications outlined in this billing policy. I also acknowledge that I am responsible for payment of all services provided, regardless of insurance coverage.

Patient Name: _____

Signature of Patient/Guardian: _____

Relationship: _____ Date: _____