MARRIAGE AND FAMILY RESOURCE CENTER
94 Rolling Hills Drive
Holland, PA 18966

OFFICE POLICIES AND PROCEDURES

1. **Payment is due at time of service. Clients are expected to make payment arrangements with billing department prior to visit. Clients must notify MFRC with insurance coverage changes. Cancellation of sessions with less than 24 hour notice incurs a fee of: $100.00.**
2. **Sessions are limited to 45-50 minutes; extra time is charged accordingly at $200 hourly.**
3. **Some MFRC providers are in-network with Aetna, United Health Care (UBH), CIGNA, Highmark BC/BS, AmeriHealth. Dr. Feinstein is also in-network with Magellan and Medicare and Penn Behavioral Health. We are out of Network on all other plans. Check with your specific provider, call your insurance carrier or call the office to get help with your insurance policies and payments.**
4. **Accounts delinquent greater than 90 days will accrue 15% (APR) interest compounded monthly.**
5. **Before the session, client are expected to contact their insurance carrier to determine what they owe for each visit with the provider. Ask specifically about:**

    a. **Deductibles**
    b. **Coinsurance or copay**
    c. **Preauthorization requirements**
    d. **Covered services (office therapy, counseling, testing, etc.)**

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made on my behalf to MARRIAGE AND FAMILY RESOURCE CENTER (MFRC) or Joan A Feinstein, PhD, JD or its agents for any services furnished me by this office. I authorize any holder of medical information about me to the Health Care Financing Administration and its agents any information to determine these benefits or the benefits payable for related sendees. I hereby authorize Medicare to furnish to the above named office any information regarding my Medicare claims under Title XVIH of the Social Security Act. I request that payment of Authorized Medigap benefits be made on my behalf to MFRC or Joan A Feinstein, PhD, JD, or its agents for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to my Medigap Carrier any information needed to determine these benefits payable for related services.

COMMERCIAL INSURANCE ***(SUCH AS AETNA, BLUE CROSS/BLUE SHIELD, CIGNA, UNITED HEALTHCARE, MAGELLAN)***

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the office indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier. I authorize release of my medical information from this office to other health care providers. A copy of this signature is as valid as the original.

INSURANCE OPT OUT _____ (initial) / SELF PAY PATIENT ***(NOT USING INSURANCE)***

I am hereby directing Joan A. Feinstein, PhD, JD, MFRC and its agents to refrain from billing my insurance company for any services rendered. I understand that by prohibiting Joan A. Feinstein, PhD, JD, MFRC and its agents from filing a claim with my insurance company, and that I am financially responsible for any services rendered.

I understand I am financially responsible for any services rendered by MFRC or its agents. I authorize release of my medical information from this office to other health care providers. A copy of this signature is as valid as the original. I understand that I am responsible for all charges for services rendered.

NON-CONTINGENCY BILLING

I acknowledge that neither MFRC nor Joan A. Feinstein, PhD, JD will not charge me on a contingency fee basis. The fees for services rendered are not dependent upon the resolution or outcome of my claims against third parties.

ASSIGNMENT AND RELEASE/CONSENT TO TREATMENT

I assign directly to MFRC or its agents all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid for by insurance. I authorize the use of my signature on all insurance submissions. MFRC, Joan A Feinstein, PhD, JD or its agents may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed and the balance is satisfied. I voluntarily and willingly agree to evaluation and treatment. I may withdraw this consent and discontinue the evaluation and treatment at anytime with notice.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. _____**(initial) /**

BY SIGNING BELOW, I INDICATE THAT I HAVE REVIEWED THE MFRC POLICIES, THIS PATIENT RESPONSIBILITY FORM, HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS, THAT I UNDERSTANDS ITS CONTENTS, AND THAT I AGREE TO ALL TERMS AND CONDITIONS.

X _____ Date: _____
(Signature of Patient, Parent, Guardian, Responsible Party or personal Representative)