NYSTROM & ASSOCIATES, LTD.
www.nystromcounseling.com
Fee and Policies Agreement

Apple Valley | Big Lake | Bloomington | Brainerd/Baxter | Cambridge | Coon Rapids | Duluth | Eden Prairie
Elk River/Otsego| Maple Grove | Minneapolis/St. Paul | Minnetonka | Rochester | St. Cloud | Woodbury

Fees/Insurance

If you plan to submit your own claims to your insurance company, it is our policy that payment of the entire fee is due at the time of service.

As a service to our patients, Nystrom & Associates, Ltd. (NAL) staff will submit your insurance claims. Please provide us with the necessary information. If you fail to provide active insurance information in a timely manner you will be held liable for this negligence. CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. DEDUCTIBLES AND COINSURANCES ARE REQUESTED TO BE PAID AT THE TIME OF CHECK IN. In the event the undersigned is entitled to health insurance benefits of any type, insuring patient or any other party liable to the patient, their benefits are hereby assigned to this health care facility for application to the patient's account. I authorize this healthcare facility to release information, including medical records, to my insurance company or the designee of my third party payer (authorized agent) as may be necessary to determine benefits, process and pay health care claims, and perform quality of care reviews at NAL.

_____ Insurance Coverage

Initial Here

NAL can make no guarantee that your insurance company will provide payment for services rendered. IT IS YOUR RESPONSIBILTY TO KNOW WHAT IS AND IS NOT COVERED UNDER YOUR POLICY. YOU ARE RESPONSIBLE FOR THE FULL AMOUNT OF THE CHARGE, WHETHER OR NOT YOUR INSURANCE WILL COVER ANY PORTION. If your insurance company requires preauthorization of services you are responsible to inform us. Be aware that some insurance companies have an annual maximum benefit for outpatient mental health coverage.

Time billed for court appearances, court case review, report writing, letters, telephone consultation, and other charges excluded by insurance coverage are your responsibility. Charges vary based on time spent and type of service.

A service charge of 1.5% (18% annual rate), or the highest statutory amount allowed, whichever is higher, will be charged on accounts past due 28 days. If payment from insurance is not received within 90 days the account may be due and payable in full by the patient. An account 90 days past due will be subject to collection procedures and/or small claims court, and the patient agrees to be held responsible for the cost disbursement, including reasonable attorneys, collection, and court fees. NAL may use the information listed below to contact you regarding your account. There is a fee of $30 for checks returned for insufficient funds. Minnesota Care Tax will be added where applicable, and you agree to be held responsible for these fees.

_____ Cancellations

Initial Here

NAL requires a 24-hour notice when cancelling an appointment. This will allow us to schedule the time for someone else. Please note: **IF YOU DO NOT ATTEND A SCHEDULED APPOINTMENT OR CANCEL WITH LESS THAN 24-HOUR NOTICE, YOU WILL BE CHARGED A FEE THAT CORRESPONDS TO THE SCHEDULED LENGTH OF YOUR SESSION**. Your insurance cannot be billed for missed appointments. At the discretion of NAL your services may be discontinued due to excessive failed appointments or late cancels.

_____ Divorce/Custodial Situations

Initial Here

The parent or guardian who brings the child in for care will be considered the responsible party and will receive all billing statements and letters. Any court-ordered financial arrangements must be worked out between the parents of the children.

Attestation for Consent

By signing this document you understand that this becomes your electronic signature for the following forms: Initial Treatment Plan, Updated Treatment Plans, and the DBT Agreement Form. The provider will ask for your verbal consent after reviewing the forms with you.

NAL may contact you via text message or email. NAL is not financially liable for any charges you incur from your service provider(s).

I hereby acknowledge that NAL's HIPAA/Notice of Privacy Practices and Patient or Consumer Rights Handout, procedures for reporting alleged violations of patient's rights and grievance procedures have been made available to me.

I HAVE READ AND AGREE TO THE ABOVE AND HEREBY GUARANTEE PAYMENT OF ALL CHARGES FOR SERVICES WITH THE FINANCIAL ARRANGEMENTS OF NAL.

_____	_____
PRINTED NAME OF PATIENT	PATIENT DATE OF BIRTH
_____	_____
PRINTED NAME OF LEGAL GUARDIAN	PHONE NUMBER OF LEGAL GUARDIAN
_____	
ADDRESS OF LEGAL GUARDIAN	
_____	_____
EMERGENCY CONTACT	PHONE NUMBER OF EMERGENCY CONTACT
_____	_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN	DATE
_____	
EMAIL ADDRESS OF PATIENT OR LEGAL GUARDIAN	