

**Driftwood Psychological Services**  
664 Scranton Road, Suite 201, Brunswick, GA 31520  
Phone: 912-230-2436

**Financial Policy & Agreement**  
**Authorization to Charge Credit/Debit Card for Insurance Denials or Those Electing Not to Utilize Insurance**

We recognize the need for a definite understanding between you and your counselor concerning healthcare and the financial arrangements for this care. Our commitment is to provide the very best services to our clients while recognizing the need to limit services to only those that are medically necessary. The responsibility for payment of fees for these services is the direct obligation of the client.

**Insurance:**

You recognize that your health benefit plan is an arrangement between you, the enrollee, and the insurance company, HMO, or your employer. While we will try to be helpful, and we may participate in the plan, your health benefit plan determines your coverage, any requirements for prior authorization or referrals, as well as any limits on your coverage for mental health services. We cannot know the benefits and exclusions of each client's policy. It is the client's responsibility to know and understand his or her coverage and benefits. We will seek to obtain verification of your eligibility; however, even when such eligibility and/or benefits are verified, your insurance plan will not guarantee the accuracy of their confirmation of coverage or benefits, that you are eligible and that your benefits are in force. It is also your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals from primary care physicians, pre-certification, limits on outpatient charges, specific physicians and/or clinics to use. You should be knowledgeable of any deductibles, co-payments, and/or co-insurance. You agree to accept responsibility for co-payments, deductibles, and medical care and other services that are provided to you which are not specifically covered by your insurance plan or not covered due to the absence of authorizations/referrals you are obligated to obtain under your insurance plan. The services, plans, and benefits under your insurance plan may be subject to and governed by applicable contracts and government regulations. This agreement is not intended to conflict with or circumvent the provisions of such contracts and regulations, including any provision regarding grievance procedures that may be available to you.

**Non-covered charges:**

A non-covered charge is any service that is denied by your insurance carrier due to benefit descriptions or limitations, policy exclusions, or preexisting waiting periods. Non-covered services will be the responsibility of the client and payment is due at the time of service.

**Electing Not to Utilize Insurance:**

You have the right to elect not to utilize your insurance coverage for any services rendered. In such cases, you are responsible for the entirety of the payment, which shall be due at the time of service.

**Out-of-network Insurance:**

Some insurance plans and policies may be considered out-of-network with our providers. For these policies, we will be happy to assist you in providing you with the information that would be needed for you to submit to your insurance agency on your own. Please be aware that we cannot guarantee what your individual insurance policy or plan may or may not reimburse to you for out-of-network services provided.

**Updating Information:**

Please be sure we have the most current demographic and insurance information at all times. It is your responsibility to provide us with this information. The information you provide us must match the information you provide the insurance carrier. Filing insurance claims with the wrong information delays processing and may increase the client's financial responsibility. Please note, if you fail to provide us with correct insurance information, we will not re-file a claim to the correct insurance after 30 days and the

balance will become your financial responsibility.

**ACCEPTANCE OF POLICY:**

I have read and do understand the contents of this form and am authorizing Driftwood Psychological Services to charge my credit or debit card should my insurance company deny reimbursement for services rendered or if I should elect not to utilize my insurance.

**CREDIT / DEBIT**

**VISA#** \_\_\_\_\_ **CV CODE** \_\_\_\_\_ **EXPIRATION DATE** \_\_\_\_\_

**MASTERCARD#** \_\_\_\_\_ **CV CODE** \_\_\_\_\_ **EXPIRATION DATE** \_\_\_\_\_

**NAME ON CARD** \_\_\_\_\_

**BILLING ADDRESS** \_\_\_\_\_

\_\_\_\_\_

Please sign and date your name below indicating that you have read and understand the contents of this form.

\_\_\_\_\_  
Client name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Date

**If Applicable:**

\_\_\_\_\_  
Parent's or Legal Guardian's name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's or Legal Guardian's signature

\_\_\_\_\_  
Date

The signature of the counselor below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

\_\_\_\_\_  
Counselor's signature

\_\_\_\_\_  
Date