Stephanie Lacy, LCSW LMFT, LLC

PSYCHOTHERAPY

Financial Policy and Assignment of Benefits

It is the policy of my office to request payment for services at the time the service is rendered. If it would be more helpful for you to pay the deductible and co-pay, I will be glad as a service to file your insurance for you. However, I cannot guarantee payment in part or in full by any insurance company or other third party, and therefore, you are ultimately responsible for any charges you incur. Co-payments are requested at the time of service. Your insurance requires that we collect a co-pay according to my contract with them. I accept payments by credit card, debit card, cash or check. However, there is a 3% service charge for debit/credit cards payments. If you incur a balance and it is not paid within 30 days from the date of service, a $25.00 billing fee will be added to your balance.

Missed Appointments and Cancellations

I require a 24-hour notice of cancellation if you are unable to keep your scheduled appointment. There will be a charge of $75.00 for any appointment which is not cancelled with a 24-hour notice. For art journaling missed appointments that were confirmed on the prior Friday, there will be a charge of $15.00. Please be aware that your insurance company will not reimburse for missed appointments.

Insurance Information

Insured's Name: _____ Insured's Date of Birth: _____
Insured's Phone No.:_____ Insured's SS#: _____
Insured's Address: _____
City: _____ State: _____ Zip: _____

Primary Insurance

Insurance Co.: _____ Policy #: _____

Employer: _____ Group #: _____

Secondary Insurance

Insurance Co.: _____ Policy #: _____

Employer: _____ Group #: _____

Note: In cases of divorce and/or separation, the parent who originally brought the child in for services is responsible for paying the office, regardless of which parent is legally responsible for insurance coverage and medical bills, as established by a divorce or any other agreement. Assignment from the non-custodial parents insurance carrier will be accepted only after this office has his/her signature on file.

I HAVE READ AND UNDERSTOOD THE ABOVE BILLING POLICY, I AGREE TO PAY FOR SERVICES UNDER THE CONDITIONS AND SPECIFICATIONS SET FORTH IN THIS BILLING POLICY AND ACKNOWLEDGE THAT I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES PROVIDED, REGARDLESS OF INSURANCE COVERAGE.

Assignment of Benefits: I authorize the release of any information necessary to process claims and direct payment to myself or the provider who accepts assignment.

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Signature of Client, Parent or Guardian Relationship to Client Date

404-345-7062
770-234-5448 (FAX)

LACY THERAPY
Clinical Social Worker • Marriage & Family Therapist

311 GREEN STREET
SUITE 408
GAINESVILLE, GEORGIA 30501