SHERMAN COUNSELING

FINANCIAL POLICY

We strive to exceed expectation and eliminate financial surprises for all of our patients. We want to partner with you in keeping your account accurate and up-to-date. Your patient financial rights and responsibilities are listed below. Please review and sign this document. The original document will be placed in your patient record and a copy given to you for your records by request.

_____ (initial) **I am solely responsible for payment for any services provided, including but not limited to: denied claims, deductibles, co-insurance and/or copayments.**
We will assume your deductible has not been met until your insurance company informs us otherwise.

I understand that I am responsible for determining whether services are covered under my health insurance plan.

I will be responsible for the full charged amount if I do not provide Sherman Counseling, LLC with my insurance information. I understand that Sherman Counseling, LLC has the right to impose a late fee of 1% per month on all amounts not paid within 30 days of billing. If an account is referred to an attorney for collection, patient agrees to pay Sherman Counseling, LLC's attorney fees. I further understand Sherman Counseling, LLC will honor all discounts, fee schedules, and network participation pricing as per signed contract. Discounts assigned by organizations or insurances without a signed agreement with Sherman Consulting LLC will become the patient's responsibility.

I understand that if my health insurance does not include coverage for behavioral health benefits, I will be required to pay at the time of service. I have the right to establish a payment plan when costs exceed my ability to pay.

I understand that Sherman Counseling, LLC does not bill secondary insurance, or submit charges directly to a Flexible Spending Account. If you allow us to copy your secondary insurance card, we will provide you with account information generally required by most secondary insurances or flexible account managers.

_____ (initial) I understand that I need to cancel an appointment 24 business hours prior to the scheduled appointment or a **NO SHOW / LATE CANCEL CHARGE of $150** will be applied to my account except in the case of emergency. For appointments that exceed an hour in duration, a no show fee will be assessed for each hour scheduled. This charge is not covered by insurance and will be my responsibility.

_____ (initial) **I have been made aware by Sherman Counseling, LLC and understand that services provided are OUT OF NETWORK with my insurance company; which may result in a higher patient responsibility. I am responsible for understanding my out of network benefits.**

_____ Print Name	_____ Client signature	____/____/_____ Date
_____ Parent - Print Name	_____ Parent Signature	____/____/_____ Date

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OSHKOSH, WI 54904
920.230.2065

477 S NICOLET RD
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2270 HOLMGREN WAY
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