BALANCED LIFE COUNSELING LLC
950 West Monroe – SUITE G100
JACKSON, MI 49202 (517)962-5022 FAX: (517)962-5195

BLC'S FINANCIAL POLICY

The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. Please be advised that payment of your bill at time of service is part of your treatment.

All patients must complete our information and insurance forms; provide a copy of your insurance card and driver's license, before seeing the therapist.

BLC confirms your insurance coverage before we schedule an appointment with you. After BLC confirms your insurance coverage, it is **YOUR RESPONSIBILITY** to notify us if there are any changes in your coverage. You are also **responsible for all copays and deductibles**. If you are unable to make these payments, we will work with you on setting up a payment schedule.

If you do not have insurance, you will be eligible for a sliding fee rate which is based on your annual income. (Proof of income [your last MI Income Tax return or the last 2-3 pay stubs] is required.)

Collection of Fees: As stated above, you are responsible to pay your copay and deductibles on your insurance. Please pay on the day of your appointment. We take cash, checks, or credit cards. We also work with you on a payment schedule.

Minor Patients: The adult accompanying a minor, or the guardian(s) of the minor, is/are responsible for full payment of services. In the case of divorce, the custodial parent is the responsible party for our fees.

MISSED APPOINTMENTS: A No Show is when you do not call to cancel or reschedule 24 hours before your scheduled appointment. Failure to call deprives another person of an appointment in your time slot. It also deprives your therapist of his/her livelihood, as he/she only gets paid for sessions when he/she actually sees a client.

Please let us know if you if you have any questions or concerns.

Your signature imply s agreement with our financial policy.

I, _____ have read the Financial Policy. I understand and agree to the terms and conditions of Balanced Life Counseling's Financial Policy.

_____

Signature of Patient or Responsible Party & Date

_____

Signature of Witness (Clinician or Administrator) & Date

Revised 10/17/18File location: Desktop BLC Forms & Letters; File name: Fin Policy