Crossroads Counseling Center
300 Main St. Suite 230, Dubuque, IA 52001
Phone: (563) 556-0699 Fax: (563) 583-3077
E-mail: info@crossroadsdbq.com

FINANCIAL POLICIES FORM

- **It is important that you understand your insurance coverage.** For any benefit information, please call the member number on the back of your insurance card. It is your responsibility to check your plan's limitations, exclusions, co-payments, and deductibles.

- In order to comply with health insurance contracts, **payments are due at the time of service or immediately following insurance claim processing.** We are not allowed to waive any co-pays, deductibles, or coinsurance amounts.

- **We recommend you have a credit card on file to help with the payment process.** We will only charge your card for copays on the date of service. If you have a past due balance we will contact you before charging your card. If you do not wish to keep a card on file, you are asked to pay at the time of service. Credit card numbers will be kept in a secure location. If insurance later covers your bill, you will be reimbursed by Crossroads Counseling Center.

INSURANCE/BILLING PROCEDURES

- **If you are electing to pay privately, the entire service fee is due at the time of service.**

- It is your responsibility to provide us with the most updated insurance information. You will be responsible for any claims denied or not covered by your insurance company due to inaccurate information or lapse in coverage.

- In the case that a bill should be accrued and you are unable to pay the full amount, you may complete a payment plan agreement with your therapist.

- **You are responsible** for charges not eligible and/or covered by your insurance plan. If you end treatment at any time, you are responsible for the remaining portion of the bill.

- If the payment agreement is not honored and/or there is any portion of the bill that has not been paid within 60 days of ending treatment, Crossroads Counseling Center reserves the right to turn the bill over to a collection agency. By signing this form, you are acknowledging that in this circumstance, you are waiving your right to confidentiality regarding information needed to collect the debt.

Client/Guardian Signature: _____ Date: _____

CREDIT CARD INFORMATION

Client Name: _____

Full name on card: _____

Type of card (MasterCard, Visa): _____

Credit Card Number: _____

Expiration Date: _____

CVV Code (last 3 digits on back of card): _____

Billing Address of Primary Card Holder:

Street Address: _____

City: _____

State: _____

Zip: _____

Authorized Signature: _____

Date: _____