Counseling & Health Center

317 West “F” Street Ontario, CA 91762
Phone: (909) 391-3051 / Direct: (714) 325-5621 / Fax: (909) 391-3068

FINANCIAL POLICY

Please understand that payment of our bill is considered a part of your treatment. Counseling & Health Center will bill your insurance; however, you are responsible for co-payment amounts and deductibles as set by your benefit plan. Co-payment amounts may very during the course of treatment, as outlined by your plan. Co-payments are due payable at each appointment.

If at any time during your treatment you become ineligible for coverage by your insurance, you will be responsible for 100% of your bill. You are responsible for obtaining any prior authorization for treatment from your insurance carrier. For special modalities of treatment not covered by your benefit plan, a written agreement will be signed between you and your clinician. This agreement should cover the fees and treatment plan and should never contain fees more than the fee-for-service discount rates that your benefit plan provides.

Minor Patients:
The adults accompanying a minor and the parents or guardians are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved payment plan or payment or payment by cash or check at time of service has been verified.

Missed Appointments:
Unless canceled, at least 24 hours in advance, there will be a $40.00 charge for missed appointments. Emergency situations will be considered. Please help us serve you better by keeping scheduled appointments. Not showing up for 2 appointments can result in being discharged from the practice.

Miscellaneous Fees:
There will be a charge of $20.00 for forms requiring provider signature (e.g. disability) and $20.00 for forms/letters requiring completion by a provider. Please allow at least two weeks for these forms to be completed. The fees for more complex forms/reports will vary & will be need to be discussed with the provider.

Please sign below indicating your understanding of Counseling & Health Center financial policy:

Patient or Guardian's Signature

Date

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ASSIGNMENT OF BENEFITS

Authorization To Pay Benefits To Provider

I hereby authorize payment directly to the Provider of service for mental health benefits, if any, otherwise payable to me for services, but not to exceed the reasonable and customary charge for those services.

Signature of Patient, Legal Guardian / Legal Representative

Date

Name of Signatory

First Name

Middle Name / MI

Last Name