



At Harmony, we are committed to providing high-quality mental health care to our patients. To ensure a seamless and efficient experience for both our valued patients and our dedicated staff, we have established this Patient Financial Policy. This policy outlines the financial responsibilities of our patients, setting clear guidelines for payments, insurance processing, and appointment management.

Your responsibilities:

Insurance Coverage, Co-payments, Coinsurance, and Deductibles:

- You are required to provide current insurance information during each visit.
- You are responsible for all applicable co-payments, coinsurance, and un-met deductibles at the time of your visit and service.

Payment Methods and Credit Card on File:

- A debit or credit card must be kept on file for automatic payment processing up to \$400 without prior notification (excluding Medicaid products).
- We accept payments through MasterCard, Visa, Discover, and AMEX, as well as personal checks.
- A \$25.00 fee will be charged for returned checks due to non-sufficient funds.

Insurance or Third-Party Assignment of Benefits:

- You assign any insurance or third-party benefits available for your services to be paid directly to Harmony.
- In the absence of assigned benefits, you agree to forward all payments received for services directly to Harmony.

Prompt Payment of Statements:

- It is your responsibility to settle your balance within 14 days of receiving electronic or paper statements.
- Outstanding balances exceeding \$150 must be addressed before scheduling your next appointment.

Non-Covered Services:

- You are accountable for any payments related to goods and services not covered by your insurance plan.

Self-Pay Rates:

- Self-pay rates are available upon request if services are not billed to your insurance company or if you do not have insurance coverage.

Missed Appointments/Late Cancellations:

- We require at least 24-hour notice for appointment cancellations.
- Late cancellations and missed appointments will result in a minimum fee of \$50, unless prohibited by your insurance.

I have read and understand Harmony's Patient Financial Policy. I grant Harmony the right to bill and collect from my insurance plan. I acknowledge my financial responsibility for all medical goods and services provided. I agree to accept electronic statements via text/email.



For minors (under 18) or adults with legal guardianship, the parent/legal guardian must sign below.

Patient Name: _____

Parent/Legal Guardian Name (if applicable): _____

Signature: _____ Date: _____

Credit Card Payment Authorization

At Harmony, we ask that a credit card be on file as a convenient method of paying for products and services that are not covered by your insurance plan or the portion that you owe after your health plan pays its portion of your claim. Your credit card information is kept confidential and secure in compliance with the Payment Card Industry Data Security Standards. We only charge your credit card for products and services that are not covered by your insurance plan, or after your health plan makes its payment to us or if you do not have insurance coverage. We may charge up to \$400 each billing cycle without authorization. The charges will be reflected on your normal credit card statements.

By signing below, you authorize and request that Harmony charge your credit card for any balance due as your financial responsibility. This authorization relates to all charges not covered by your insurance company for products and services provided, including but not limited to deductibles, co-pays, and products not covered by insurance and appointments that are missed or not timely canceled in compliance with our cancellation policy. Your card will remain securely stored for future use for payments of balances due from you.

You agree not to dispute any of the charges made to your credit card for any of the above reasons. In addition, you agree not to initiate or pursue a chargeback or payment reversal after your credit card has been charged for any of the above reasons.

This authorization will remain in effect until you revoke it in writing, which you may do at any time.

If the credit card that you give today changes, expires, or is denied for any reason, you agree to immediately provide us with a new, valid credit card, which you agree may be keyed-in over the phone. Even though we are not swiping this card in person, you agree that the new card may be used with the same authorization as the original card that you provided.

For minors (under 18) or adults with legal guardianship, the parent/legal guardian must sign below if the responsible party.

Patient Name: _____

Responsible Party (if not patient): _____

Signature: _____ Date: _____