

Northshore Clinic and Consultants

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Cedarburg, WI 53012

www.northshoreclinics.com /262-375-1116

Financial Policy, Patient Payment Plan, and Good Faith Estimate

August 6, 2024

Dear Northshore Clinic Clients,

Thank you for choosing Northshore Clinics and Consultants for your counseling care. To continue providing quality services, we have updated our fees and financial policies effective October 1, 2024. These changes will reduce administrative burden and allow our team to focus more on your health and wellness.

We understand that this may raise some questions and concerns, so we aim to clarify our new policies below.

All intake paperwork must be completed online or in person prior to your first appointment. A credit card on file is required to schedule appointments and will be billed for any balance on the 1st of each month. Flexible installment plans are available if you cannot pay your balance in full. Payment plans must be arranged prior to the next calendar month to avoid any interruptions in treatment. Payments can be made online, by phone, or in person.

For those who wish to utilize insurance benefits, we will continue to submit claims on your behalf, but it is your responsibility to understand your insurance benefits and manage claims that are not accepted. If insurance denies a claim, you are responsible for the balance. For patients whose insurance we do not accept, we will provide a bill for you to submit to your insurance company. Our office staff can assist you in navigating that process.

Patients undergoing financial hardship, who meet certain income requirements, may qualify for a sliding fee discount or temporary financial aid. Please speak with your therapist or our office staff to apply.

Our updated fee schedule is as follows:

- 90791 (Initial Assessment): \$200.00
- 90837 (53-60 min): \$150.00
- 90834 (38-52 min): \$100.00
- 90853 (Group Therapy): \$75.00
- 90785 Interactive Complexity (if not covered by insurance): \$25 per 15-minute increments.

**These services are outside of session time (e.g., consultations with family members or other professionals) are not covered by insurance and will be billed at \$25 per 15-minute increment*

- \$2.00 Service Fee for all credit card payments.
- Cancellation without adequate notice/ No Shows may be charged up to 50% of session fee.
- Executive/ Life Coaching Session: \$125.00

Self Pay Discounted Day of Service Payment:

- Day of service payment qualifies for a 10% discount [applies to updated fee schedule rate only].

Self Pay Pre-Pay Packages:

- 5 sessions: 15% discount
- 10 or more sessions: 20% discount

Thank you for your continued trust in us. Please feel free to contact us at 262-375-1116 or visit www.northshoreclinics.com.

Sincerely,

The Team at Northshore Clinic and Consultants

Northshore Clinic and Consultants Financial Policy Acknowledgement

1. Responsibility for Payment

- All patients are required to pay the full cost of services, this includes balances not covered by insurance that are deemed patient responsibility. Payment methods accepted include credit/debit cards, checks, and cash. Credit card transactions require a \$2.00 processing fee.
- All patients are required to have a current credit card on file. Balances will be processed on the first of each month unless other payment plan arrangements have been made in advance.

2. Insurance Submissions

- If you prefer to have NSCC submit a claim to your insurance provider, please be aware that any unpaid balance after the claim is processed becomes your responsibility.
- If you choose to Self-Submit to your insurance company, you will be provided with a detailed receipt and a "superbill." This superbill includes all necessary information, such as diagnostic codes, service descriptions, and provider details, that your insurance company will require for processing your claim. Please be aware that reimbursement is a matter strictly between you and your insurance company.

Filing a Self-Submitted Claim:

You are responsible for submitting the superbill to your insurance company. It is important to familiarize yourself with your insurance policy's requirements and deadlines for claim submission.

3. Understanding Your Insurance Coverage

- **Verification of Benefits:**
We strongly recommend that you verify your insurance coverage before your first appointment. This includes understanding deductibles, co-pays, out-of-network benefits, and any restrictions or limits on mental health services.
- **Out-of-Network Services:**
If we are not in-network with your insurance provider, services rendered at Northshore Clinic and Consultants may be subject to out-of-network rates. You are responsible for understanding your out-of-network benefits and paying for services in full at the time they are rendered.

4. Payment Plans

- **Installment Payments:**
If you are unable to pay the full amount at the time of service, we offer payment plan options. These must be arranged in advance with our staff. All payment plans require a signed agreement and adherence to the payment schedule.

5. Outstanding Balances

- **Late Payments and Collections:**
Any unpaid balances that are not covered by a payment plan will be considered past due after 30 days. Accounts with balances more than 60 days past due may be forwarded to a collection agency. Additional fees may apply.
- Patients with unpaid, outstanding balances will require a payment plan prior to booking any new appointments.

6. Financial Hardship

- Financial Assistance:
We understand that circumstances can change unexpectedly. If you are experiencing financial hardship, please contact our billing department to discuss possible financial assistance or adjustments to your payment plan.

7. Good Faith Estimate

- Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services. You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees. Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item.
- You can also ask your provider or office staff for a Good Faith Estimate before you schedule an item or service. If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.com.

8. Questions and Support

- Contact Information:
If you have any questions regarding this financial policy or need assistance with your insurance submission, please contact our billing department at 262.375.1116

Acknowledgment of Financial Policy

By signing below, you acknowledge that you have read and understand the financial policy at Northshore Clinic and Consultants. You agree to comply with the terms outlined above.

I confirm the accuracy of my financial disclosure and acknowledge full responsibility for fees not covered by my insurance. I understand and agree to the financial policy and Good Faith Estimate. Failure to adhere to this agreement may affect my relationship with NSCC and my treatment. This agreement is valid for one year or until revised

Patient Name: _____

Patient Signature: _____

Date: _____

Payment Source:

- Check/Cash
- Credit/Debit Card
- HSA
- FSA

- Patient Name: _____
- Cardholder Name: _____
- Cardholder Address: _____
- City: _____ State: _____ Zip: _____
- Account Number: _____
- Exp Date: _____
- 3 Digit Code: _____

Cardholder's Signature: _____

Date: _____

Northshore Clinic and Consultants Payment Plan

I consent to charging my account for the current balance owed as of today's date. Late payment and collections policies will apply if future payments are not received.

I will utilize the NSCC Pay Plan to pay past due balances. I consent to a monthly payment of \$_____ due on the first of the month, until my balance is paid in full.

Payment Source:

- Check/Cash
- Credit/Debit Card
- HSA
- FSA

- Patient Name: _____
- Cardholder Name: _____
- Cardholder Address: _____
- City: _____ State: _____ Zip: _____
- Account Number: _____
- Exp Date: _____
- 3 Digit Code: _____

Cardholder's Signature: _____ Date: _____

By signing, I confirm the accuracy of my financial disclosure and acknowledge full responsibility for fees not covered by my insurance. I understand and agree to the financial policy and understand the Good Faith Estimate policy. Failure to adhere to this agreement may affect my relationship with NSCC and my treatment. This agreement is valid for one year or until revised.