Evolve Therapy & Associates

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Welcome to Evolve Therapy and Associates Inc.

We appreciate you choosing Evolve Therapy and Associates Inc. (ETA) to meet your mental health needs. We ask that you please read the following closely as it explains pertinent information regarding ETA's clinical policies.

Appointments: if you are unable to keep your appointment, or are going to be late, please call our office as soon as possible. This courtesy allows us to make the time available to other clients. A minimum charge of $75 will be made for missed appointments or cancellations without 24 hour advance notice. Messages may be left with our answering service 24 hours a day, seven days a week.

Confidentiality: all information regarding our patients is considered strictly confidential and will not be given out to anyone without your written consent. In keeping with generally accepted procedures in the mental health field, patients are not normally given access to their chart or chart notes. In the event of a request for the transfer of records to a new therapist or doctor, the records will be forwarded directly to that person upon completion of a release of information form by the patient, and a fee may be charged.

I authorize my doctor/therapist to furnish my primary care physician and my insurance company all information, including treatment records, which they may request concerning treatment for myself and/or my dependent. Evolve Therapy and Associates is not responsible for these records once they leave our office.

Termination: Termination of treatment is best done on the basis of a mutually agreed-upon, face to face interaction with your doctor or therapist.

Financial Fees and Policies: Please understand that payment of your bill is part of your treatment and care. The following is a statement of financial policy, which we require all of our patients to read, understand, and sign prior to treatment and care. Payment is due at the time services are rendered in the office unless prior arrangements have been made with the business office. A $40 fee will be charged for any check returned by our bank as non-collectible. In order for our clinic to offer you our highest quality of services, all balances over 60 days and/or any account that reaches a balance of $300 must be paid in full before you are able to schedule future appointments. If charges are unpaid after 90 days your account may be turned over to a collection agency with any information that may be required for collection of said debt. Should your delinquent account be turned over to a collection agency or attorney, please be advised that you will be responsible for court costs, attorney fees, and collection fees.

Methods of Payment: ETA accepts cash, check, Visa, MasterCard, and Discover. We accept assignment of insurance benefits if we have a management contract with your insurance company. This will be verified at your first appointment. If we accept your insurance, you are responsible for your co-pays, contract deductibles and any amounts not paid by your insurance with the exception of provider contracted reductions.

The patient is solely responsible for obtaining the necessary authorization from their insurance affiliate for their first appointment and agrees to pay said appointment fee in full if it is later determined authorization was needed. In the event an authorization is issued but the insurance company refuses to pay for the services, the balance due will be your responsibility. *Please remember, insurance is a contract between you and your insurance company. We are not a party to this contract. You are responsible for the timely payment of your account.*

Administrative Fees: The following is a notification of our fees for services not covered by insurance. These fees will allow us to accommodate our patients request for non-covered services such as medical records, cancellations, school/work forms, etc. The fees for administrative paperwork is $40 for every half hour allocated to administrative tasks. It is the patient's responsibility to understand what services their insurance company covers. You may refer to your benefit manual or call the member services number on the back of your insurance card if you need further clarification.

Acknowledgment: I have read, understand and agree to the above clinical and financial policies. I hereby agree to assign my doctor/therapist the medical benefits to which I and/or my dependent are entitled to under any health insurance plan. I give my consent to my doctor/therapist to provide valuation, treatment, and/or other services that we may mutually determine to be appropriate. I am participating in my treatment voluntarily and I understand that I have the right to refuse or discontinue treatment at any time. I have had the opportunity to discuss my reasons for seeking services and I understand my responsibilities in the therapeutic relationship.

Patient's Name _____ Date _____

Signature _____ SIGN HERE

Guardian's Name _____ Date _____

Guardian's Signature _____ SIGN HERE

(Necessary for patients to the age of 18)