Kevin Y Riley LCSW, CADC III
Billing Information and Fee Agreement

Client Information – If the financially responsible person is other than the patient, please complete page 3 of this form.

Name: _____ Date of Birth: _____

First Middle Last

Gender: M __ F __ Age: ___ Marital Status: _____ SSN: _____

Address: _____ City, State, Zip: _____

Telephone(s): _____ _____ _____

(home) (cell) (work)

E-mail 1: _____ e-mail 2: _____

May we leave messages for you? ☐ on home phone ☐ on cell phone ☐ on work phone ☐ on email ☐ No

Fees

Intake Session / Diagnostic Interview	175.00	60-80 minutes
Individual Session	125.00	38-52 minutes
Individual Session	150.00	53+ minutes
Family / Couples Session	150.00	50 minutes
Group Session	50.00	80 minutes

Insurance information – Please provide a copy of your insurance card(s), <u>front and back</u>

Primary insurance carrier: _____ Phone: _____

Claims address: _____

Name of insured: _____ Relationship to patient:_____

Insured ID number: _____ Group number: _____

Insured date of birth: _____ Phone: _____ Employer: _____

Insured's address: _____

Secondary Insurance Carrier: _____ Phone: _____

Claims address: _____

Name of insured: _____ Relationship to patient:_____

Insured ID number: _____ Group number: _____

Insured date of birth: _____ Phone: _____ Employer: _____

Insured's address: _____

Office Policies

- **Session Fees:** Fees for Intake Session/Diagnostic Interviews are due in full at the time of session and all other session payments are due in full by cash or check at the time of the session unless prior arrangements are made.
- **Additional Service Fees:** Telephone sessions or consultations are billed at the individual session rate on a prorated basis. Preparation of reports or letters will also be billed on a prorated basis at the individual session rate. All professional services related to legal proceedings are billed at $150.00 per hour.
- **Insurance Reimbursement:** If you are using health insurance benefits, you need to be aware of your policy and its benefits and limitations. All policies are different. All payments are **due in full at the time of service** until insurance coverage is confirmed. Otherwise, co-payments are due at the time of the session. Insurance payments will be applied to your balance. Positive balances are applied to future co-payments or refunded.
- **Late fees:** A late cancellation fee of $75.00 will be charged for sessions missed without 24-hour notice (Friday notice for Monday appointments). Insurance companies do not pay for missed appointments, so you are financially responsible for them.
- **Delinquent Accounts:** If an account is seriously delinquent, I will provide 30 days notice prior to referring the matter to a collection agency. If missed appointments are a recurring problem, I may ask for a retainer before scheduling the next appointment.
- **Office Hours:** I share this building with several other healthcare professionals. Each of us is an independent practice. We have no responsibility for one another's business or patients. My office hours are M-F, 8-5. To reach me during those hours, please call 541-231-7538 and I will call you as soon as I am able. If you call after office hours, leave a message and I will try to return your call the following business day. In case of an emergency, please call 911 or go to your nearest emergency room. When I am out of town another practitioner will be available for urgent matters.
- **Confidentiality and Release of Information:** Your participant in treatment and all information about you is confidential and will not be disclosed to anyone without your consent. The only exceptions are: 1) suspected abuse or neglect of a child or an elderly or disabled person, 2) cases where I believe that the client presents an imminent risk of harm to him/herself or to another person, 3) cases where a court subpoenas my records, 4) cases where an insurance company is helping to pay fees and requires information about diagnosis or reports about treatment.
- **Unable to pay:** Clients who are unable to pay the full fee based on economic need may ask for a fee reduction. Please discuss this with Kevin.

- I understand the office policies established by Kevin Y Riley LCSW, CADC III
- I understand I am financially responsible for all charges, regardless of insurance, unless otherwise written by Kevin Riley
- I hereby authorize the release of all health care information necessary to process an insurance claim.
- I hereby authorize my insurance carrier to make payments directly to Kevin Riley LCSW, CADC III
- Past due fees may also assessed a 1.5% rebilling/past-due account fee (minimum $5.00) per month and/or may be referred to a collection agency to facilitate payment.

Client Signature: _____Date: _____

Complete this section if the financially responsible person (Guarantor) is someone other than the client

Name: _____ Date of Birth: _____
First Middle Last

Gender: M __ F __ Age: ___ Relationship to Patient : _____ SSN: _____

Address: _____ City, State, Zip: _____

Telephone(s): _____ _____ _____
(home) (cell) (work)

E-mail 1: _____ e-mail 2: _____

May we leave messages for you? ☐ on home phone ☐ on cell phone ☐ on work phone ☐ on email ☐ No

- I hereby authorize the release of all health care information necessary to process an insurance claim.
- I hereby authorize my insurance carrier to make payments directly to Kevin Y Riley LCSW, CADC III.
- I understand I am financially responsible for all charges, regardless of insurance, unless otherwise written by Kevin Y Riley LCSW, CADC III.
- I understand the financial policies established by Kevin Y Riley LCSW, CADC III.
- I understand that balances left unpaid over 90 days from the date of service may also assessed a 1.5% rebilling/past-due account fee (minimum $5.00) per month and/or may be referred to a collection agency to facilitate payment.

Signature: _____ Date: _____