COR Plus

Dear Patient,

Welcome to COR Plus. We appreciate the opportunity to be of service to you. Our office is dedicated to excellence in patient care. To maintain our high standards, we believe that it is important that we communicate our policies to you. Please take a moment to read and become familiar with these policies. Should you have any questions, the office staff is happy to help answer them. By presenting these policies in advance, we can avoid any surprises or misunderstandings. We appreciate your time and your understanding.

Patient Financial Responsibility Agreement

Payment Responsibility:
I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or my family members. I understand that payment or co-payment is due at the time services are rendered unless special arrangements have been made. It is my responsibility to confirm coverage is provided by my insurance company or other provider. I understand that if I am a Kentucky or Indiana resident that no benefits provided by the State of Ohio will be provided to me.

Charges for Additional Services:
I understand that charges will be added to my account for other professional services rendered. These charges will be in increments of 15 minutes, or by encounter, and COR Plus will always discuss additional charges with me. Other professional services include extended contact via email, consulting with other professionals (with my permission), preparation of records or treatment summaries, and the time spent performing any other service I may request.

Appointments & Cancellations:
I understand that I am required to provide at least 24 hours advance notice if unable to keep the scheduled appointment because the scheduled time slot has been reserved exclusively for me and/or my family members. In the event that I do not provide 24 hours advance notice, I am financially responsible for the reserved appointment. COR Plus may make exceptions and waive the fee, at its discretion, for emergency or unusual circumstances. I understand that insurance companies do not provide reimbursement for cancelled sessions. Repeated missed appointments may result in termination of therapy. There may be a time when my therapist or physician may need to cancel my appointment for an emergency; COR Plus will make every effort to reschedule me/my family in an appropriate time frame. This will be at no charge to me.

Returned Check Fee:
I understand that a fee of $35.00 will be added to my account for any check returned by my financial institution regardless of reason. Should a check be returned, I will not be permitted to write a check again for a period of 6 months.

Delinquent Accounts:
I understand that my account may be turned over for collection and I will be responsible for all costs of collection monies owed, including court costs, collection and attorney fees. I further understand that if I fail to make any of the payments for which I am responsible in a timely manner, I may be charged a 1.5% service charge monthly on the remaining balance.

I fully understand and agree to these policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

Patient Printed Name:_____

Patient/Parent/Guardian Signature_____

Patient Signature:_____

Date:_____