Reflections Counseling
3220 E. Jefferson BLVD, South Bend IN 46615
Phone: 574.222.2466 Fax: 574.222.2468

Financial & No Show Policy

We are committed to providing you with the best possible care in the most cost effective way possible. Please review our financial policy below. Please ask any questions you may have about this document prior to signing.

We accept cash, checks, and credit card payments; we charge a $25.00 bank charge for returned checks. Any credit card charges over $100.00 are subject to a 3% processing fee.

If you have insurance, we will work with you to help you receive the maximum benefit possible. If your insurance authorizes a service (or the service does not require authorization) and subsequently does not process the claim or denies the claim, you are responsible for the full balance.

If you have a secondary insurance and you do not provide a copy of the insurance card at the first appointment, you will be responsible for all copays resulting from your visit. Reflections Counseling is not responsible for billing your secondary insurance if you do not provide proper documentation.

Please pay all co-pays, co-insurance, and deductible amounts at the end of each session. If you cannot afford to settle your account in full at the end of a session, we do have payment plans available. We take most insurance and ask that you call the number on the back of your insurance card prior to your appointment to verify benefits and coverage.

For an account that becomes delinquent (overdue 90+ days) we reserve the right to charge a 35% collection-handling fee on the balance to send to a collection agency. At that point, you will be responsible for all costs associated with the collection process to the extent permitted by the law.

If you do not attend a scheduled appointment and do not call your therapist within 24-hours prior to the appointment, we reserve the right to charge a $65.00 no-show fee. Further, we reserve the right to refuse further appointments with you if you do not attend your appointment without 24 hours notice.

By signing below, you are agreeing to our financial policy. The enforcement of this agreement is governed by the State of Indiana. We reserve the right to change this policy at any time.

_____ (initial) I understand the certain information about me can be released to insurance companies in order to process claims.

_____ (initial) I authorize payment of medical benefits to the provider for mental health services delivered

_____ (initial) I understand that I am financially responsible for services rendered that are not covered by the above-mentioned insurance company

_____ (initial) I understand that if I do not provide 24-hours notice prior to cancelling or missing an appointment, the doctor may refuse to schedule further appointments and I will be placed at the bottom of the waiting list.

I hereby give permission to Reflections Counseling to provide me with mental health services within the scope of the provider's license, training, and supervision.

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Printed Name of Client

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Client or Parent/Guardian's signature Date

Revised 3.17.2022