Fees and Insurance Consent Form

J. Jason Chastain, LICSW, BCD, CCTP-II, GC-C
9825 Sandifur Pkwy, Suite D
Pasco, WA 99301
Office Phone: 509-531-6698
jjchastain@protonmail.com

Fees. For an initial intake evaluation, the fee for those who pay out of pocket is $210.00 and each subsequent session is $145.00 for a 1-hour session. You will be responsible for paying at the time of session. You may pay in the form of cash, check, or card. It is important that I have a debit/credit card on file for you, so on your initial session I will charge your card at least $1, even if you would not normally pay. There is a $2 fee per credit/debit card swipe for any charges $50 and over. Any checks that are returned to my office will be subject to an additional fee of up to $25.00 to cover the bank fee I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment. If you are a private pay individual you will receive a Good Faith Estimate within the first five sessions of treatment.

Late cancellations (less than 24 hours) or failure to show for a session will result in a charge. Please realize this may mean you get charged even if you are sick or physically unable to attend. In order to maintain my overhead, I must charge for sessions I cannot fill. Giving notice allows me to schedule someone else who may have been waiting. If you are more than 15 minutes late for a session insurance will not be billed, and you will be charged out of pocket for that session.

Insurance. It is your responsibility to contact your insurance provider to check insurance coverage, deductible, coinsurance, co-pay, and authorization information prior to your first appointment. Payment is due at the time of service. If you are using an insurance that I am in-network with, I will bill the insurance on your behalf. Due to the rising costs of health care, insurance benefits having increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. If your insurance company is not providing sufficient coverage you may pay for your services directly, or I can provide a referral to other mental healthcare providers.

Most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as progress notes or summaries, or in rare cases, copies of the entire record. Though all insurance companies claim to keep information confidential, I have no control over what they do once records are in their hands. In some cases, they may share information with a national medical information databank. I will provide you with a copy of any records I submit, if you request it. You understand that by using your insurance you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.

As Jason Chastain does not accept Medicare or Medicaid, he does not bill secondary insurance unless he is in-network with them. Also please understand if your secondary insurance is with the same company as your primary insurance, you are not

'double-covered'. Upon request I will provide a statement for you to submit your secondary insurance claim for reimbursement. You are responsible for any patient liability shown by a primary insurance claim. If I am out of network for your insurance plan, full payment is due at the time of service. I will then supply you with a receipt of payment for services i.e., a superbill, which you can submit to your insurance company for direct reimbursement to you. Please note that not all insurance companies reimburse for out-of-network providers.

Insurance Authorization & Financial Responsibility Statement. I hereby authorize J. Jason Chastain and Chastain Counseling, LLC to contact my insurance carrier in order to determine eligibility for medical services. I understand that my insurance will be billed for services rendered by Jason Chastain. I agree that if my insurance carrier issues a check to me in my therapist's name for reimbursement for services, I will within five days make payment in the amount of said check to the therapist. I acknowledge that it is my responsibility to contact my insurance company to determine the details of my benefits including whether my therapist is in-network with my plan, deductible information, and any coinsurance or co-payment for which I am responsible. I acknowledge that it is my responsibility to determine whether my insurance requires prior authorization for counseling services prior to my first appointment, and authorizations for continued treatment. The following also applies to the use of my insurance to cover the cost of services:

Authorization to Release Medical Information for Billing

_____I hereby authorize the release of necessary information regarding services by Jason Chastain to process insurance claims

Financial Responsibility and Authorization

_____I understand that *regardless* of my insurance benefits, I alone am fully financially responsible for the fees for the services rendered.

_____I authorize Chastain Counseling, LLC to bill the card on file if I have an outstanding copay, co-insurance or deductible payment due, or a fee for a missed session.

_____ I authorize Jason Chastain to send bills to me electronically via email.

Signature of Responsible Party_____ Date_____