Nash Therapeutic Services, LLC

Ph: 501.500.2111
Fax: 501.244.9999
http://www.nashtherapy.net

628 W. Broadway
Suite 100
N. Little Rock, AR. 72114

Self-Pay Patient Policy

Client Name: _____ Client DOB: _____

Welcome to Nash Therapeutic Services, where our professional staff are committed to providing you with the highest quality behavior analytic services. The following is a statement of our Self-Pay Financial Policy, which we require you to read and sign prior to receiving treatment.

Policy: In order to make our services accessible to clients lacking health care coverage, Nash Therapeutic Services offers a discount for self-pay patients. NTS will identify patients which qualify under this policy and consistently apply a method of billing, discounting, and collecting. Charges for hourly rates before discount are as follows: LCSW $230; BCBA $120 and line therapist $50. Self-pay clients will receive a 40% discount.

Procedure:

• Self-Pay clients will be identified when they initially contact the clinic for an appointment. A Self-Pay Patient is defined as a patient who (please initial applicable item):

❖ _____ has no health insurance coverage of any kind

-or-

❖ _____ has health insurance which does not provide coverage for the requested services

-or-

❖ _____ has health insurance but has chosen to receive services without expressed authorization from designated carrier

_____ I understand: Invoices will be sent monthly. If payment is not provided for more than two (2) consecutive invoices; services will be discontinued and the Self-Pay Discount will be forfeited. Additionally, the client will be obligated and required to pay the full charges.

Please initial only one of the following

_____ I understand: I am selecting to enroll in the self-pay program for all services and recognize that it is my responsibility to terminate participation in the self-pay program by issuing written request, no less than (30) days prior to the expected date of payer change.

_____ I understand: I am selecting to enroll in the self-pay program for selected services only and recognize that authorization for services is only provided for a select period of time. I further recognize that I will need to complete a new authorization form for self-pay should additional service(s) be needed following the completion of this authorization period.

**Must complete per service authorization section on the next page.*

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Per Service Option:

Occasionally, we find that an insurance provider may cover ABA services but omit coverage for a particular service(s). In such an event you may elect to receive the additional service by paying for the service(s) directly. By completing this section, Self-pay will be used to cover only the listed service(s), and only for the designated time period

It is the intention of Nash Therapeutic Services to utilize your insurance benefits whenever possible; however, during the course of our work together there may be times in which your benefits may change. It will be the client's responsibility to ensure that notification is given to the provider, should their insurance policy change.

Please be aware that by initializing, you are authorizing Nash Therapeutic Services to provide each service during the listed timeframe for the list number of hours. Should the service continue to be necessary following the completion of this time period or for additional hours, a new authorization must be completed. Additionally, you are indicating that you understand that the provided services will be billed directly to you the client and not to your insurance carrier.

Initial	Service to be Provided	Provided by	Start Date	End Date	# of Hrs

Authorization and Release

I have read and fully understand the Self-Pay Financial Form as outlined above. In the event it is necessary to turn my account over to collections, I have been made aware that I am completely responsible for any and all costs associated with the collections process.

By signing this form, I understand I am financially liable for all services provided to me, my dependents or any other person for which I have assumed responsibility.

_____

Printed Responsible Party Name

_____ _____

Responsible Party Signature
or Enter SSN for Digital Signature

Date