H3 - Hope Healing & Health, Inc.
23100 Jefferson Avenue
Saint Clair Shores, MI 48080-2057
Phone: 586-335-2006 | Fax: 586-279-3886

Missed Appointment Policy 2022

Name * #PatientName **Date of Birth:** #PatientDoB

I have given all updated insurance information to H3 to verify my yearly benefits. I am responsible to obtain my individual benefits information from my insurance company directly in order to be prepared for the actual cost of my visits.

I will give up to date changes to H3 regarding my insurance so I do not occur costs related to my care.

I understand that I am ultimately responsible for charges related to my treatment.

I am aware that my insurance company will be billed but this is not a guarantee of payment.

I am aware that I must contact the office/therapist to cancel 24 hours in advance of my scheduled.

Cancellation of a session must be done within 24 hours of scheduled appointment--or the client is responsible for missed appointment fee of $80.00 for appointments with therapists and $150 for appointments with NP/Doc/Psychiatrist/Psychologist, except in cases of emergency. Late fees will be posted to the InSync client portal automatically when sessions are missed. You will be able to view this charge within your individual client portal at the time of the fee.

I will put a credit card on file with InSync as I understand H3 is currently not taking cash/check due to the COVID-19 pandemic.

I am aware that each insurance claim is billed under the clinical director, Dr. Emily Escott and her name and NPI will be on my explanation of benefits for therapy. And for medication claims, it will be billed under Motor City Medical.

FINANCIAL RESPONSIBILITY:

I am aware that payment for services is expected at the time of service and I have an updated card on the InSync system.

CREDIT CARD AUTHORIZATION:

I hereby authorize H3-Hope, Healing & Health, LLC to deduct the payment for professional service fees or missed appointment fees using the HIPPA Compliant Payment Vendor - EasyPay through InSync HealthCare Management

"I have read the Practice Policies and Financial Responsibility Agreement and understand the expectations during the duration of my therapeutic relationship with H3-Hope, Healing & Health, Inc"

Name * #PatientName

Signature

Date: #CurrentDate