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## **Financial Policy and Agreement**

In this document, I have written important information about my financial policies. Please read it carefully. I am happy to discuss any questions with you. When you sign this document, it represents an agreement between us.

You are financially responsible for all charges whether or not paid for by insurance. If you choose to use an insurance policy to pay for a portion of your care, I may be required to submit certain information about you, including a diagnosis and occasionally detailed information such as evaluations and treatment summaries. I strive to protect the release of sensitive information as much as possible while still meeting the “authorization” requirements.

You are under no obligation to use your insurance. You may prefer to avoid filing insurance, having your diagnosis disclosed, or having your care reviewed by a managed care organization (which may request photocopies of all of your personal records for review) by selecting a private pay cash agreement.

If you elect to use your insurance to partially pay for your care, it is your responsibility to verify your insurance coverage and note any restrictions or limitations. Please understand that some or perhaps all of the services provided may be “non-covered” services or, not considered medically necessary by your insurance carrier. If you want to use your insurance, you should:

- a) determine if I am a contracted provider with the plan and, if not, whether there is an out-of-network option covering non-paneled providers;
- b) obtain authorization for your initial visit;
- c) determine the co-payment you are required to pay for my treatment services; and
- d) determine the amount of remaining unpaid deductible for your benefit year, the number of visits allowed per benefit year, and the beginning date of the benefit year.

**\*If you change insurance plans during the course of your treatment, you are required to notify me immediately and provide a copy of your new insurance card in order for insurance billing to take place.**

### **Fees for my professional services are charged as follows and may change over the course of your treatment depending on the length of your treatment.**

- \* Initial psychiatric evaluation is \$160.00
- \* 20 minute medication management follow-up session is \$60.00
- \* 25 minute therapy and medication management session is \$60.00
- \* 50 minute therapy and medication management session is \$110.00
- \* 50 minute therapy session is \$100.00
- \* Evaluations, letters, and reports required by an employer, the legal system, or other entities are billed at \$100.00 per 50 minutes (this includes chart review/preparation time.) These charges are not covered by insurance, and will be billed directly to you.
- \* Phone calls lasting more than 5 minutes may be prorated at the above rates.
- \* **Appointments not kept and/or not canceled at least 24 hours in advance will be charged to you at the rate for the service and time scheduled. Insurance will not cover these charges.**

You are expected to:

- 1) Pay the amounts not covered by your insurance plan (i.e., co-payments, unpaid deductibles, missed appointment fees) at the time of service unless other arrangements have been made;
- 2) **If your insurance benefits have not been verified prior to your first appointment you will be required to pay 100% of the cost of your of the visit at the time of service, any adjustments will be reflected on your monthly statement;**
- 3) Pay outstanding amounts on your statement within 30 days;
- 4) If your account is overdue and sent to an attorney or collection agency to pursue collection, you will be responsible for any and all collection fees, court costs, attorney fees, and filing fees;
- 5) Pay a \$15.00 charge on any returned checks; and
- 6) Pay on unpaid balances over 30 days, 1.5% per month interest charges.

If you have any questions or concerns about the fee policy or your fee, I am happy to address them with you. **Please check one of the following:**

- I will not be using my insurance to pay for any part of my care. I will pay the full amount of each session at the time of service.
- The clergy of my church will be helping to pay for my care. I will sign a full release of information to him/her and provide billing address, and contact telephone number at time of appointment. I will obtain a signed document from them indicating their willingness to pay for services, what portion they will pay, and for how long payment is to be rendered.
- I want to use my insurance benefits to pay for a portion of my care.

*If I am using my insurance carrier(s) to partially pay for my care, I give permission to Shauna Norton, APRN, to release all necessary diagnostic and treatment information to the insurance carrier(s), and authorize my insurance carrier(s) to pay policy benefits directly to Shauna Norton. I request that this assignment of benefits remain on file with my insurance carrier(s).*

*I understand that I am financially responsible for all charges whether or not paid for by insurance, including missed appointments, and sessions not canceled more than 24 hours in advance. I authorize the release of necessary information to a collection agency if that should become necessary. I permit a copy of this signed agreement to be used in place of the original.*

**I have read and understand the Financial Policy and Agreement, and I agree to the conditions and terms therein:**

\_\_\_\_\_  
**Signature of person responsible for payment**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of client (if different than responsible party)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Date**