Attachment & TRAUMA THERAPY
913.346.1516 | attachmentandtraumatherapy.com

FOX CHILD & FAMILY THERAPY
913.229.5691
foxchildtherapy.com

Missouri
222 W Gregory Blvd, Ste 120, Kansas City
9200 NE Barry Rd, Ste 110, Liberty
2900 NE 60th St, Ste 206, Gladstone

Kansas
7223 W 95th St, Ste 220 & 300, Overland Park
25255 W. 102nd Terrace, Suite 200, Olathe

Billing Policies and Guarantor Form

Therapist Fees

- **Initial/Diagnostic Assessment Session (50 minutes): $165.00**
- **Individual (50 minutes): $140.00**
- **Couple/Family (50 minutes): $140.00**

Patients are responsible for all fees, deductibles, co-payments, co-insurances and balances at the time of service. Clients are responsible for understanding their insurance plan and tracking these amounts. Attachment and Trauma Therapy dba Fox Child and Family Therapy (AATT) will charge the card on file at the time of service and will refund what insurance ends up covering. If an Explanation of Benefits (EOB) indicates additional patient responsibility, AATT will automatically charge the card on file and send an email statement.

Additional fees apply for offsite meetings, letters, and observations outside of therapy (not billable to insurance). For clients with accepted insurance, contracted rates apply, which may differ from listed fees (CPT codes: 90791, 90837, 90834, 90832, 90846, 90847, 90785, 90839).

Additional Fees

- Billable Phone Calls (prorated in 15-minute increments, minimum 15 minutes):
  - 15 min: $35.00
  - 30 min: $70.00
  - 45 min: $105.00
  - 60 min: $140.00
- Letter/Report Writing: $140.00/hr
- Returned Check Fee: $40.00

Court/Legal Related Fees

Court Attendance (including preparation, depositions, testimony, mileage, attorney fees, etc.): **Minimum $5,000.00** (details below).

- Preparation Time (including record submission): $500.00/hr
- Phone Calls/Emails: $500.00/hr
- Depositions/Court Hearings: $500.00/hr
- Consultation with Other Professionals: $500.00/hr
- Attorney Fees and Costs Incurred by Therapist
- Minimum Court Appearance Fee: $5000.00 (additional charges for appearances exceeding 5 hours)
- Records Requests/Administrative Costs: $100.00 minimum

A $5,000.00 retainer is required in advance. A $200.00 express charge applies for subpoenas or attorney meetings with less than 2 weeks' notice. A $500.00 fee applies if a case is rescheduled with less than 1 week's notice (in addition to the retainer). Costs will be discussed with the client.

Financial Responsibility and Billing Guarantor

AATT uses a biller to process claims and payments, requiring access to protected patient information for insurance submissions. Your signature below authorizes this. Initial insurance verification confirms active coverage but does not guarantee payment amounts. Clients are responsible for understanding their insurance plan's *behavioral health coverage* as behavioral health benefits vary plan to plan even in the same network. Clients are responsible for communicating any updates or changes to their benefits and in the case of any lapse in coverage are responsible for our private pay service rates. Any remaining unpaid balances are the client's responsibility and will be charged to the card on file.

Unpaid balances are charged to the card on file; if declined, AATT will contact you by phone. A $15 weekly late fee applies if the card is declined (unless prohibited by your payer). Clients with unpaid balances cannot schedule appointments. After two cancellations due to non-payment, services may be terminated, with outstanding balances still owed. Amounts sent to collections may incur additional fees. Parents or guardians are responsible for minors' treatment costs, regardless of insurance determinations.

Notice of Financial Responsibility

I understand that payment for all services is due at the time of service. The parent and/or legal guardian who signs this form (the "Billing Guarantor") is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I am responsible for any costs incurred in collecting a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to AATT to release any pertinent information to my insurance company upon request and authorize payment directly to AATT. A photocopy of this authorization shall be considered as effective and valid as the original.

Non-Covered Services

I am aware that some services performed by AATT may be considered "non-covered" by my insurance carrier or Medicaid; therefore, I will become fully responsible for payment of these services.

Divorce/Child Custody

AATT will not honor specific financial arrangements in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgment, or similar ("Arrangements"). As AATT is not a party to these Arrangements, it is not obligated to their financial terms.

In child custody cases, the individual who has signed the Guarantor Form is financially responsible for payment of all fees, including co-pays, co-insurance, and deductibles at the time of service. This responsibility applies regardless of joint-custody arrangements, joint responsibility for medical expenses, or which parent presents the child for care. AATT will not be responsible for coordinating payment or reimbursement between parties. If the responsible party is not the Presenting Parent, they may call in to update the payment method and ensure the account remains in good standing. Upon request, AATT will provide a duplicate receipt so the presenting party or guardian can seek reimbursement where appropriate.

Notice of Privacy Practices

I have reviewed AATT's Notice of Privacy Practices, which explains how protected health information will be used and disclosed. I understand that AATT has the right to change its Notice, effective for health information already held about my child[ren] as well as any received in the future. AATT will post a current copy of the Notice; I may request a copy at any time.

Billing Guarantor Signature/Contact Information

I have read all of the above and agree to all provisions regarding financial responsibility, permission for treatment, and Notice of Privacy Practices.

Billing Guarantor Name: _____

Relationship to Patient:

○ Parent ○ Self ○ Legal Guardian ○ Foster Parent ○ Other_____

Guarantor Date of Birth (mm/dd/yyyy): _____

Primary Phone: _____

Address / City / State / Zip: _____

_____ _____

Guarantor Signature Date