Adoption & Attachment Therapy Partners, LLC

Arleta James, LPCC
1201 Canyon View Road
Sagamore Hills, OH 44067

Phone: 330-813-2525
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Helping adoptive parents forge strong connections among all family members via adoption-attachment-trauma informed therapies.

NOTICE OF FINANCIAL AND SCHEDULING POLICIES

We are dedicated to providing you with the highest quality healthcare. Beyond services provided to you in this office, we work with many insurance companies who help coordinate your healthcare and also help you meet your financial responsibility. If you have questions about your billing, please do not hesitate to contact our administrative assistants at 440-746-9099, ext. 1 or adoptattachtherapy1@gmail.com.

Your responsibility begins when you call to make an appointment. Please know your PASSS approval and please provide a copy of your PASSS approval. Be aware of what your copay is.

All services are rendered to you as the patient. Therefore, all charges are ultimately your responsibility for payment. You will be expected to sign a form as acknowledgment of your financial responsibility.

Self-Pay
Patients who are not covered by PASSS, a current insurance plan, or who do not present a current insurance care at the first session, are required to pay in full for all charges on the day of service. Checks are made payable to "Adoption & Attachment Therapy Partners LLC." Checks may be given to your therapist or the administrative assistants. There is a $20.00 charge for all returned checks. Payment arrangements can be made under certain circumstances.

PASSS Funding
PASSS is between the county and the family. It is the family's responsibility to know what the PASSS approval covers, and what the family's copay is. We will submit your services to your county as long as you have provided us with the proper information to do so. You will be responsible for copays. You will be responsible for any services that exceed your PASSS approval. It is best to touch base with the administrative assistants throughout the PASSS year to make sure that PASSS funds are available to cover the scheduled services. It is also a good idea for parents to keep track of the PASSS funds spent throughout the course of the PASSS year.

Medicaid
We do not accept Medicaid as a method of payment.

Divorce/Child Custody
The parent accompanying the child to their first visit will be expected to sign the billing form, and is ultimately responsible for the bill. Copies of the divorce decrees providing the court order for mental health treatment are also required.

Unaccompanied Minors/Students
All minors/students must have a parent accompany them to the first appointment to provide

demographic information and sign our office policy forms.

Missed appointments/late cancels
Unless cancelled 24 hours in advance, our policy is to charge – full price – for missed appointments. **This charge goes to the family - not to insurance or PASSS funding.** Please allow us to serve you and other clients better by keeping scheduled appointments.

Additional Information
At times, temporary financial problems may affect the timely payment of your account. You are encouraged to contact and keep in touch with us at 440-746-9099 to do everything possible to keep your account in good standing. Outstanding PASSS copays that carry over from one PASSS year to the next, must be paid in full (or to the satisfaction of the administrative assistants) before services can resume in the new PASSS year.

Scheduling Appointments
Therapists schedule appointments directly with their clients. The therapists certainly do their best to help see to it that children and teens are able to attend school and after school activities. Yet, this is not always possible. We cannot always guarantee after school and weekend appointments. In such situations, parents will need to make a choice as to what the most important priority is for their son or daughter.

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CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____and Adoption and Attachment Therapy Partners LLC. When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written his or her name here:

_____

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you, and to provide any treatment to you. We may also share this information with others who provide treatment to you, or need it to arrange payment for your treatment, or for other business or government functions.

By signing this form, you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices (NPP) explains in more detail your rights and how we can use and share your information. Please read the NPP before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future, we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change the NPP, you can obtain a copy from our Privacy Officer.

If you are concerned about some of your information you have the right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer, telling us you no longer consent), and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client or parent/legal guardian if minor Date

_____ _____

Printed name of client or parent/legal guardian if minor Relationship to client

_____

Signature of authorized representative of this practice

DATE OF NPP _____ _____Policy given to client/parent/legal guardian

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