Village Mind and Body Institute
Office Fee and Insurance Policy

We are committed to providing you with the best possible care we can give you. If you have behavioral health insurance, we are more than happy to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance and your understanding of our policy.

Billing of Insurance/Assignment of Benefits/Payments
We do not participate in any behavioral health insurance plans, as a courtesy we can file a claim on your behalf, so that you may get reimbursed. You will be responsible for any deductible, co-pays and any denied claims. Insurance benefits will vary among the many different plans. We will verify your insurance information for you, but insurance companies will NOT guarantee to us that this information is accurate until the claim has been submitted for review. Also, please know that, over time, your insurance plan may change your benefits. They do not notify us of these changes so please inform us if there are any changes to your plan.

Missed Appointment Policy
A significant amount of time is blocked out of the practitioner's schedule for each session. When appointments are not cancelled in advance, it prevents us from being able to offer that appointment time to others. Therefore, a fee of $50.00 is charged for each missed session NOT cancelled by **telephone** (352-405-6733) within 24 hours PRIOR to the appointment. There is a fee of $100.00 charged for each missed testing appointment.

Please Note: If 3 missed appointments occur within a 12-month period, your account will be charged for any further missed appointments at the regular session rate.

Credit Card Authorization: I hereby grant permission to charge my card for any remaining balance, missed appointments, telehealth or emails in excess of 5 a month or any other fees that are owed or are outstanding, also we provide a free 15-minute consultation, after that time there will be a fee charged.

Credit Card Number or Debit Card:_____

Expiration Date:_____ Security code on back _____ Billing Address Zip Code_____

Name on Card _____

Cardholder's Signature_____ Today's Date_____

I have read and understand the office fee policies and agree to abide by them.

_____. _____

Patient Name Patient Signature or Guardian