Soonie A. Kim, Ph.D.

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Financial Policy

In the interest of a cooperative working relationship between myself and my clients, please carefully read the financial policy as described below. If you have any questions or concerns regarding this policy, I encourage you to speak with me at your first appointment.

Insurance Billing and Client Fees: As a courtesy to clients, I will bill your primary insurance for services rendered providing you submit all the necessary information enabling me to do so. Client out-of-pocket expenses such as deductibles, co-payments, and co-insurances are due at the time of service. Please be aware that no-show and late cancellation fees are not billed to insurance and are due by the client on or before your next scheduled appointment.

Insurance Delinquent Balances: I consider it my responsibility to provide clients and their families with quality care. In exchange, I ask that clients work with their insurance companies to compensate me in a timely manner for services rendered. While I do my best to collect on all insurance claims, in the end, I cannot accept responsibility for continued follow up on past due claims or negotiating a disputed claim. Thus, I require that insurance balances past due by 90 days and/or equal to or greater than $1,000.00 be paid by the client in full in order to continue services. You will be given adequate notice and referral options should your treatment need to be postponed until delinquent insurance balances have been resolved.

Client Delinquent Balances: Client balances (not owing by insurance) are due in full within 30 days of receiving your monthly statement. Please be advised that accounts past due by 90 days, unless payment arrangements have been made with the billing department, may be sent to collections. As a courtesy to clients, a collections warning letter is sent indicating the status of your account. You will be given 10 working days to respond to this notice before action is taken. If you discontinue treatment at any time and your account is delinquent or assigned to collections, you will not be allowed to come back to therapy until your balance has been paid in full. Further, if you name me as a debtor when filing bankruptcy you will not be able to return for services.

Receipts: Receipts will be provided at the time of payment. I recommend that you maintain a record of your visits and payments for any reimbursement that your employer or others may require.

Returned Checks: There is a $25.00 processing fee on returned checks. I require that your returned check amount plus the processing fee be paid in full on or before your next scheduled appointment.

Signing below indicates 1) I have read, understand and agree to abide by Dr. Kim's financial policy. 2) Dr. Kim has my permission to bill my insurance company. 3) I authorize her to release any information necessary to process my claims. 4) I authorize that my insurance benefits be paid directly to Dr. Kim.

Financially Responsible Party:

Signature: _____ Date: _____

Printed Name: _____ Relation to client: _____