Center for Tranquil Transitions, LLC

72 E. Holly Ave – Suite 106
Pitman, NJ 08071
Telephone: (856) 582-6000 / FAX: (856) 582-6005
http://www.centerfortranquiltransitions.com/

Payment and Cancellation Policies

Fees:

The client of Center for Tranquil Transitions, LLC promises to pay all charges incurred for services rendered. The clinician will complete all insurance claim(s) and release necessary documentation to complete said claims.

Fees for court appearances, phone sessions, copies of records etc. will be discussed with you by therapist, as the need arises. Phone consults initiated by the client, that exceed 10 minutes will be billed in quarter hour increments based on the per session fee.

Co-pays and Insurance:

Your co-pay is expected at the time of your services. Your clinician (Cristina E. Mazzeo, LPC) will file the client's initial insurance claim(s) and provide documentation necessary for insurance reimbursement. However, your clinician cannot guarantee that any/all services will be covered and/or what those percentages or coverages may be. Please note, there may be time where the client may have to intervene, by contacting the insurance company regarding non-payment of claim status. In the event insurance refuses to cover services rendered, clinician (Cristina E. Mazzeo, LPC) will work with client to establish a workable financial plan to cover payment. In the event of an outstanding balance (post 30 days) additional late fees of $20 will be incurred, until rectified.

Checks, cash and credit cards are accepted forms of payment. If you are going to use a check please have it ready when you come in to save time.

Cancellation Policy:

Cancellations must be done within a 24 time frame of your appointment. A fee of $50 will be charged to those who cancel with less than a 24 hour notice, unless it is due to illness or emergency.

Thank you for your consideration regarding this important matter.

Credit card information to be kept on file, including expiration date, CVR code, and billing zip code is required. Signing this form is an acknowledgment that you agree to be charged on this card in the event of a late cancellation or no-show. No-show fee is $50.

Credit Card (Type/Acct #) _____

Name on card _____

Expiration Date _____

CVR code _____

Zip code of billing address _____

Insurance will not be billed for missed/canceled appointments.

Your signature indicates that you have read the above and agree to the terms contained therein.

_____ _____

Client Signature Date

_____ _____

Clinician Signature Date