## FINANCIAL AGREEMENT

# STANDARD FEES:

The standard fee is $220 for the initial session which includes diagnostic assessment. Following the initial session the standard fee is $145 per 45 minute session. These rates may be adjusted through contract with some insurance providers or other third party contract.Fees are subject to change with a 30 day notice.

# INSURANCE REIMBURSEMENT:

If you have medical insurance providing coverage for mental health counseling, we can help you receive your maximum allowable benefits. We accept assignment of benefits (direct reimbursement from insurance companies) when authorized by you at the bottom of this form.

Processing your insurance claims and tracking reimbursement is a benefit we provide for you. To do so we need your up-to-date insurance information. To avoid a delay in reimbursement, we ask you to inform us if your insurance plan changes or you are issued a new insurance card. As a service to you, we will check co-pays/co-insurance and deductibles with your insurance company at the time we receive your insurance information. *Remember this information is no guarantee of benefits. You are ultimately responsible for any cost not covered by your insurance plan.*

**INSURANCE INFORMATION:*(Fill out or provide a copy of insurance card(s) and required information.)***

***Primary* (Copy of insurance card provided: 🞎 Yes 🞎 No )**

|  |
| --- |
| **Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Policy Holder Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Client’s Relationship to Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

***Secondary*(Copy of insurance card provided: 🞎 Yes 🞎 No , if applicable)**

|  |
| --- |
| **Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Policy Holder Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Client’s Relationship to Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

|  |
| --- |
| ***I understand that I am responsible for all charges regardless of insurance coverage!*** |

**ASSIGNMENT OF INSURANCE BENEFITS:**

The undersigned hereby authorized the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my therapist to submit claims for benefits without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Authorized Signature of Subscriber Date**