FINANCIAL AGREEMENT Contract for Services

Name: _____
Address: _____City: _____State:_____ Zip: _____
Phone Number (Home): _____ Cell or other: _____

Bill to: Person Responsible for Payment on Account: _____
Address (if diff than above): _____City: _____
State: _____ Zip: _____ Contact Number: _____

Federal Truth in Lending Disclosure Statement for Professional Services Part I: Fees for Professional Services

- I (we) agree to pay Jennifer Smith, MS, LPC, hereafter referred to as the clinic, a rate of $160.00 for the first diagnostic session and $95.00 per clinical unit thereafter (defined as the 45-50 minute session for assessment, testing, individual, family, and relationship counseling). The fee for testing includes scoring and report writing.
- A fee of $15.00 is charged for group counseling, per person per session.
- A fee of $95.00 is charged for missed appointments or cancellations with less than 24 hours of notice.
- Any check that is returned for insufficient funds will be charged the amount of the check and a $20 processing fee.

Part II:
Clients with Insurance (Deductible and Co-Payment Agreement)

This clinic has been informed by either you or your insurance company that your policy contains, but is not limited to, the following provisions for mental health services:

Estimated Insurance Benefits

1. $_____Deductible Amount (paid by insured party)
2. Co-payment _____% ($_____/ clinical unit for the first _____visits.
3. Co-payment _____% ($_____/ clinical unit up to _____visits.
4. The policy limit is _____ per year.

We suggest you confirm these provisions with the insurance company. The Person Responsible for Payment of Account shall make payment for services which are not paid by your insurance plicy, all co-payments, and deductibles. We will also attempt to verify these amounts with the insurance copmahy.
Your insurance company may not pay for services that they consider to be nonefficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services)./ If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part I above.

Part III:
All Clients

Payments, co-payments, and deductible amounts are due at the time of service. There is a 1.5% per month (18% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.

Signature of Person Responsible for Account Date

Release of Information Authorization to Third Party

I (we) authorize Jennifer Smith, MS, LPC, to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to In Courage Counseling, LLC.

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one yaer this consent expires. I (we) have been informed what written information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) Responsible for Account _____ Date: _____

Person(s) Receiving Services _____Date: _____

Person(s) or Guardian(s) _____Date: _____