



Financial Information 2018

THERAPY SERVICES: Session services will be directly billed to client's insurance or immediately collected as a *Self-Pay* client with an agreed upon pay schedule. Insurance Co-pay amounts (as printed on insurance card) will be due at each session.

INSURANCE INFORMATION / THIRD PARTY PAYMENT: As a licensed mental health provider, many insurance plans will help pay for therapy services. There is also a possibility that your health insurance plan will not cover outpatient mental health services. It is your responsibility to obtain your mental health benefit information from the customer service number on your insurance card. In either case, the financial responsibility for services is yours as a client/parent. In addition, mental health collaboration with other professionals (with a signed release form), e.g., school counselors, physicians, may be needed and most insurance companies do not cover these expenses. This will require us to bill you directly.

CANCELLATION POLICY requires that 24-hour notice be given if it is necessary to cancel or change an appointment. If this notice is not given, a \$70 charge will be applied. Insurance companies are not responsible for these cancellation charges.

PERSON(S) RESPONSIBLE FOR THIS ACCOUNT

Name: _____ DOB: _____ Phone: _____

Address: _____ Zip Code _____

***Primary Insurance** _____

Name of Subscriber: _____ DOB: _____

ID#: _____ Group#: _____ Employer: _____

*I have contacted or will contact my Insurance Company to verify my Mental Health Benefits.
I understand this is my responsibility.

Signature _____

PATIENT/PARENT GUARDIAN AGREEMENT and ASSIGNMENT OF BENEFITS

- I have been notified that there is the possibility that outpatient mental health services may not be a covered benefit by my health insurance. If my insurance is not in effect today or a service is not a covered benefit, I agree to be financially responsible for the charges that occur today and any subsequent charges that may occur.
- I give this office permission to release any information to my insurance company necessary to obtain authorizations or support any insurance claims relating to my treatment and secure timely payments due to the assignee or myself.
- I hereby assign medical benefits, including those from government-sponsored and other health plans to Gail L. Bos, **Living Beyond Counseling**. A photocopy of this assignment is to be considered as good as the original.

Client _____ **Date** _____
(Parent/guardian)

PLEASE MAKE SURE WE HAVE A COPY OF YOUR INSURANCE CARD