Financial Agreement

Primary Insurance_____ Phone #_____

Policy/ID#_____ Group/Plan#_____

Policy Holder_____ DOB:_____ Employer _____

I authorize the release of any medical information necessary to bill insurance claims. I permit a copy of this authorization to be used in place of the original.

Date:_____ Client Signature:_____

Our office is pleased to accept your insurance assignment. After verification of coverage we will file your claim forms and assist you in every way we can. However, it must be fully understood that the contract is between YOU and your insurance company and you are fully responsible for any amount not paid by your insurance company. Out office does not guarantee that your insurance company will pay. We will make every attempt to verify your insurance coverage. However, if for some reason your insurance claim is denied, you are responsible for the full amount of the bill. We will not enter into a dispute with your insurance company over your claim. That is your responsibility and obligation. I hereby authorize Stephanie Weiland, LLC to apply for benefits on my behalf for covered services rendered by this office. I request that payments from my insurance be made directly to Stephanie Weiland, LLC. Should an insurance payment inadvertly be sent to me, I will endorse it and return it to Stephanie Weiland, LLC immediately. I understand that I am financially responsible for any unpaid balance by the insurance company within sixty (60) days of the date of service. I certify that the information I have reported with regard to my insurance is accurate. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time by written request.

Date: _____ Client Signature: _____

I agree to pay $_____ for a deductible and/or $_____ per session for a copay, and I agree that if I pay for any fee or bill with a credit or debit card, I understand that there will be an additional 3.5% service charge and that I must have a card on file in order to hold appointments with my therapist.

I understand that if I request my therapist to write a report outside of a regular session time, I will be billed according to the amount of time the report takes my therapist to write. For example, if the report takes the therapist thirty minutes and their hourly fee is $120, then the report will cost $60. I also understand that if I request my therapist to consult with teachers, principals, other doctors, social workers, attorneys and/or any other professionals, there will be a charge for the therapists time required for the consultation. I agree to prepay for this service with cash or a check when it is requested, or I agree for my therapist to charge my card on file at the time of the consultation and/or report writing service.

I understand that all appointments not cancelled 24 hours in advance will be charged at the full therapist's rate for the time reserved for the session to my credit or debit card on file including the 3.5% service charge. Although my therapist understands that there will likely be times when I may need to cancel an appointment, that the time has still been set aside only for me and I am still responsible for the session fee. I understand that a $30 service charge will be added to all returned checks and the fee will be charged to my card on file. I agree to pay all reasonable collection or legal fees should Stephanie Weiland, LLC need to use an outside collection agency or legal means to collect on this account. Balances older than 30 days may be subject to additional interest charges of 10% per month. The undersigned will be responsible for all costs incurred in the collections of any past due account, including attorney's fees.

I understand and agree with all of the above. Please sign your name below and we will accept your assignment.

Date: _____ Client Signature: _____

I have explained the financial agreement to the above named client(s).

Date: _____ Therapist Signature: _____