PAYMENT CONTRACT FOR SERVICES

The following is a statement of the financial policy. It is requested that you read and sign this statement prior to beginning services.

Full payment is due at time of service: Check, Cash, Visa/MC/Discover/Amex

REGARDING INSURANCE:

You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk of confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into an insurance database and reported to the National Medical Data Bank. Accessibility to computer systems is always in question as computers are inherently vulnerable to unauthorized access. Medical data has also been reported to be legally accessed by enforcement and other agencies including those offering life or health insurance.

Should you elect to file with your insurance, we are happy to provide you with a statement of services and to discuss the diagnosis submitted. In some situations, it may be agreed upon that Eddins Counseling Group will bill insurance companies and other third-party payers. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company. As such, we cannot guarantee insurance benefits or the amounts covered, and are not responsible for the collection of such payments. The balance is your responsibility whether your insurance company pays or not. In some cases insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. Payments not received after 60 days will be billed to you. We charge clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

All insurance benefits will be assigned to this provider unless the Person Responsible for Payment of Account pays the entire balance each session.

RELEASE OF INFORMATION AUTHORIZATION TO THIRD PARTY

I (we) authorize and consent for ___________________________________ to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to a third-party payer or insurance company for the purpose of obtaining authorization and receiving payment directly to ____.

I (we) understand that access to this information will be limited to determining insurance authorization and benefits, and will be accessible only to persons whose employment is to provide clinical authorization, and determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions. I assign my insurance benefits to the provider listed above. I understand that this form is valid while I am an active client with Eddins Counseling Group unless I cancel the authorization through written notice.

Person(s) responsible for account: ____________________________________ Date: ___/___/___

Person(s) receiving services: ____ Date: ___/___/___

Person(s) or guardian(s): ____ Date: ___/___/___

Payment Contract for Services

Full payment is due at time of service. Payment methods include: Check, Cash, Visa/MC/Discover/Amex. A $25 fee will be assessed for all returned checks. Clients using charge cards may sign below allowing the provider to automatically submit charges to the charge card after each session and can change payment method or charge cards at any time.

Federal Truth in Lending Disclosure Statement for Professional Services

Part One Fees for Professional Services

$__________per visit (defined as 45–50 minutes) $ _________for testing (________________)

$___60 _____is charged for missed appointments or cancellations with less than 24 hours notice.

Part Two Charges:

Clients are responsible for payments at the time of services, including testing fees, deductibles, and co-payments. Although it is possible that deductible amounts may have been met elsewhere, this amount will be collected at the time of service until the deductible payment is verified by the insurance company or third-party provider. Services will be terminated if timely payment is not made as agreed to by this consent.

Part Three Minors:

The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied non-emergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at the time of service.

Thank you for understanding the financial policy and payment contract. Please let us know if you have any questions or concerns.

I (we) have read, understand, and agree with the provisions of the Financial Policy and Payment Contract for Services.

Person responsible for account: ____ Date: ___/___/___

Payment Authorization for Services

I authorize Eddins Counseling Group to keep my signature on file and to charge my credit card account for:

- All balances not paid by insurance or other third-party payers after 60 days.
- Recurring charges (session fees, co-pays) as per amounts stated above.

All credit card payments are deemed final.

Client's Name:	**Cardholder's Name:**
Cardholder's Billing Address:	
Card Type:	**Expiration Date:**
Account Number:	**Security Code:**
Cardholder's Signature:	**Date:**