CENTERED
COUNSELING

FINANCIAL AGREEMENT AND INSURANCE INFORMATION

Client Name: _____

Date of Birth: _____

Social Security number: _____

If we are in your insurance provider network, your insurance will pay a fee negotiated by your insurance. You can expect your portion to be your typical copay. If we are providing services using your insurance for out of network benefits, the exact breakdown of your portion of the service will vary based on your specific plan. We encourage you to check these benefits by calling the number on the back of your insurance card. Typically insurance companies have been very responsive to their own client inquiries. If you have questions, we would be happy to assist you. For individuals paying out of pocket, the following rates are standard. Individual clinicians may provide a sliding scale based on financial need, please inquire with each clinician.

FINANCIAL AGREEMENT

Standard Fees and Charges

- Individual & Family Therapy $200 for therapeutic hour (50 minutes) or rate negotiated by insurance
- Individual Mental Health Assessment: $250 per intake, or rate negotiated by insurance

Agreement to Pay:

- I understand that I am financially responsible to my provider for services rendered.
- I agree to pay the co-pay, coinsurance, and any deductible stipulated by my insurance plan.
- Payment is due at the time of my appointment unless other arrangements have been made.
- Credit card payments will be charged an additional 3.5% processing fee
- It is my responsibility to inform my provider of any changes that affect the billing or charges to my account. This includes third-party payers, income, or family status.
- I understand that standard collection procedures will be followed if payment is not made.

I agree to the above statements: _____

Insurance Information

Primary Insurance: _____

Policy Number: _____

Insured's Name: _____

Insured's Date of Birth: _____

Insured's Address: _____

Insured's Phone Number: _____

Relationship to Client: □ Self □Spouse □Parent □Other

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance: _____

Policy Number: _____

Insured's Name: _____

Insured's Date of Birth: _____

Insured's Address: _____

Insured's Phone Number: _____

Relationship to Client: □ Self □Spouse □Parent □Other

Insured's Employer: _____

Employer's Address: _____