Adult

Financial agreement

Fees:

Some or all of the appointment fee may be covered by insurance. However, insurance often requires copayment (set amount), coinsurance (percent), or deductible amounts. It is your responsibility to verify the specifics of your coverage. You also have the option to self-pay if you prefer to opt out of utilizing insurance coverage or have no insurance coverage. Payment can be check, cash, or credit card and is due at the time of service.

Cancellation:

Appointments missed without canceling will require a $50 fee. Cancellations with less than 24 hours notice will require a $50 fee unless deemed an emergency When therapy becomes difficult it can be easy to avoid attending sessions; talk about these feelings with your provider.

Billing Insurance:

In order to submit a claim for services covered under your insurance policy, we must have authorization to release medical information for paper or electronic billing.

By signing below, I acknowledge the following:

1. *I authorize Alternative Perspectives Counseling, LLC, to file for benefits on my behalf for medical services rendered.*
2. *I authorize the release of any medical information necessary, on paper or electronically, to bill insurance and process my claims.*
3. *I am aware that I am financially responsible for all services not paid by insurance and acknowledge it is my responsibility to know my individual policy (including copay and deductible amounts) and to inform the therapist of any changes to my insurance.*
4. *I am aware that this authorization is valid indefinitely until revoked in writing by myself or by the provider.*
5. *I further authorize that payment be made to Alternative Perspectives Counseling, LLC on my behalf.*
6. *I release my provider and its' officers, agents, employees, and any clinicians associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.*

Credit Card Authorization:

Credit Card Information				
Card Type:	☐ Mastercard	☐ Visa	*I authorize Alternative Perspectives Counseling, LLC, to use the credit card information below to pay any invoices (i.e., professional services and cancellation fees) for my account and can request copies of invoices at any time. I understand that my information will be saved for future transactions, and this authorization will remain in effect until canceled. I certify that I am an authorized user of this credit card and that I will not dispute any payment with my credit card company so long as transactions correspond to terms indicated in this form. I will notify my provider of any changes to this information.*	
	☐ Discover	☐ American Express		
Cardholder Name (as on card):				
Card Number:				
Expiration Date (mm/yy):				
CVV:	Zip code:			

Patient Name (please print)

Patient or Guarantor Signature

Date

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