



Edward Clark, LPC, CCADC  
4015 Nine McFarland Drive, Suite 175  
Alpharetta, GA 30004  
678.982.9039 office  
ed@lifefocus.biz

**Insurance Financial Policy and Fee Agreement – page 1 of 2**

**Fee:** My fee for appointments 55 minutes in length is \$120.00 for individuals and/or couples. Insurance only covers sessions that are 60 minutes or less. I understand that at times, you as a client may need additional time. I would be happy to set up an appointment with you the following business day in order to continue your session as well as remain in compliance with the insurance requirements.

**Payment:** Services are to be paid for in full with cash, check, debit or credit card at the end of each session. In the event you are unable to pay, there is an additional \$35.00 charge on top of all additional fees. All fees must be paid in full prior to scheduling any future appointments.

**Credit card on file:** You agree and give consent and authorization to Life Focus, Inc. to charge the credit card on file for any remaining balance. If you do not provide a credit card number to keep on file, you will be required to provide a \$100.00 deposit (in cash or check that will be deposited). The fee will only be utilized in the event you do not show up for an appointment or do not give a 24-hour notice for cancellation. If the deposit is utilized as mentioned above, you will be required to provide an additional \$100.00 (cash or check) prior to setting up an additional appointment. The \$100.00 cannot be used towards the payment of a session.

**In network:** If I am in your insurance network, you are expected to pay the fee required by your insurance company at the time of service. If benefits have not been verified, you will be expected to pay the full service fee (listed above). You are responsible for knowing the details of your insurance coverage and obtaining authorizations as required by your health plan. I will file with your insurance carrier, however you will want to call and verify your mental health coverage prior to your appointment. The policies and procedures of your insurance health plan will govern fees and payment of fees for professional services. All fees that are not covered by your insurance carrier are your responsibility. \*Please note that most insurance companies DO NOT cover marriage therapy and you will be required to pay the full fee of \$120.00 per 55-minute session.

**Out of network:** If I am not in your insurance network, the full fee is to be paid at each session at the private pay rate (listed above) and you will be responsible for filing with your insurance for *possible* reimbursement. If you have questions regarding your coverage, it is recommended that you contact your insurer directly. I will provide a receipt or statement as needed.

**Cancellations/Missed Appointments:** It is important that you keep your scheduled appointments. Appointments not cancelled 24 hours in advance will be billed \$100.00 Insurance **does not** cover these charges therefore we will not submit a claim to your insurance company.

**NSF/Returned Checks and Credit Card Declines:** NSF/Returned checks or credit cards that are declined will be subject to a \$35.00 service fee.

**Insurance Financial Policy and Fee Agreement – page 2 of 2**

*I have read and understand the above stated information. I understand that I am financially responsible for all charges, regardless of insurance, unless otherwise written by Edward Clark, LPC of Life Focus, Inc. I understand the financial policy established by Edward Clark, LPC of Life Focus, Inc.*

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client Name: (Please print): \_\_\_\_\_

**Billing Information and Benefit Verification Form**

**Patient Information (Please print clearly)**

Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: (if applicable) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Private/personal Email: \_\_\_\_\_

May messages be left for you at: Cell? \_\_\_\_\_ Work? \_\_\_\_\_ Email? \_\_\_\_\_

**Insurance Information – Please provide a copy of your insurance card(s), front and back, or bring your card(s) to your first appointment so that copies can be made.**

**Primary Insurance Carrier:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Claims Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relation to Client: \_\_\_\_\_

Insured ID number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insured D.O.B.: \_\_\_\_\_ Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

Insured's Address (if different than yours)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I hereby authorize the release of all medical information necessary to process an insurance claim. I hereby authorize my insurance company to make payments directly to Edward Clark, LPC of Life Focus, Inc. I understand that I am financially responsible for all charges, regardless of insurance, unless otherwise written by Edward Clark, LPC of Life Focus, Inc. I understand the financial policy established by Edward Clark, LPC of Life Focus, Inc. I understand that balances left unpaid over 30 days from the date of service may be assessed a 1.5% re-billing/past due account fee (minimum \$5.00) per month and/or may be referred to a collection agency to facilitate payment.

**Name (please print):** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\*\*\*\*

**For office use only:**

Authorization needed? \_\_\_\_\_ Obtained? \_\_\_\_\_ Auth #: \_\_\_\_\_

# of visits authorized: \_\_\_\_\_ Start Date: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Deductible: \_\_\_\_\_ Met: \_\_\_\_\_ Co-pay/Co-ins: \_\_\_\_\_

Benefits Limits: \_\_\_\_\_ How much used? \_\_\_\_\_

Marriage Therapy: \_\_\_\_\_ Family Therapy: \_\_\_\_\_

CS Rep/Verified by: \_\_\_\_\_ Date: \_\_\_\_\_