Life Focus, Inc.

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Insurance Financial Policy and Fee Agreement – page 1 of 2

Fee: My fee for appointments 55-60 minutes in length is $175.00 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. Rates are subject to change but notice will be given.

Payment: Services are to be paid 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.

In network: You are expected to pay the fee required by your insurance company at the time of service. It is your responsibility to send us this completed form at least 24 hours prior to your appointment in order for benefits to be verified. If benefits have not been verified, you will be expected to pay the full private pay 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 a claim with your insurance carrier, however, you will want to call to verify your mental health coverage before 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 couple/marriage therapy and you will be required to pay the full fee of $175.00 per 55-60 minute session.

Out of network: You are expected to pay the full private pay rate (listed above) at each session 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.

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 (including balances for denied claims). 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 any additional appointments. The $100.00 deposit cannot be used towards the payment of a session.

Cancellations/Missed Appointments: It is important that you keep your scheduled appointments. Appointments not canceled 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 debit/credit cards that are declined will be subject to a $35.00 service fee.

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): _____

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: _____
Messages be left for you at: Cell? _____ Work? _____ Email? _____

Insurance Information – ***Please provide a copy of your insurance card (front and back), as well as a copy of your driver's license (to prevent fraud), or bring this information to your first appointment so that copies can be made.***

Primary Health Insurance Company: _____ Phone: _____
Claims Address: _____
City: _____ State: _____ Zip: _____
Member ID number: _____ Group Number: _____
Primary Policyholder: _____ Relation to Client: _____
Primary Insured D.O.B.: _____ Phone: _____ Employer: _____
Primary 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:** _____

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For office use only:

Authorization needed? _____ Ref/Auth #: _____ Date: _____

# of visits authorized: _____ Start Date: _____ Exp Date: _____

Deductible: _____ Rem: _____ OOPM: _____ Rem: _____

R&C: _____ Co-pay: _____ Coinsurance %/rate: _____ Benefits Limits: _____

Couples/Marriage Therapy:_____ Family Therapy: _____