TRUTHERAPY

FINANCIAL AGREEMENT

INSURANCE PROCESSING

Our office participates with a variety of insurance and EAP plans. We file your claim to your insurance company as a courtesy. You are financially responsible for all services not paid by your insurance company. It is your responsibility to bring your insurance card to every visit and notify us of any changes in your insurance coverage, if you have a secondary insurance, and any key demographic changes. In agreement with the services that will be provided by TruTherapy LPC, I hereby agree and authorize my insurance company to pay this practice in full for services rendered in accordance with my medical benefits as agreed to in my insurance policy. I hereby authorize TruTherapy LPC to release to my insurance company any information necessary for seeking reimbursement for the services listed below.

We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to know your own insurance benefits, including whether we are contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company. If you have any questions, please contact your insurance company plan administrator.

PAYMENTS

All applicable co-payments, deductibles, or any other out-of-pocket expenses are expected to be paid at the time of the appointment. The co-payment/co-insurance/deductible is your responsibility and payments are expected at the time of your appointment. Payment is accepted by cash or credit card. TruTherapy LPC reserves the right to increase fees in the future to a reasonable amount and you will be given adequate advanced notice if this should occur.

MISSED APPOINTMENTS

I understand that it is my responsibility to schedule and ensure that these appointments are kept. I understand that if I am unable to attend my scheduled appointment that I must call, cancel, or reschedule my appointment at least 24 hours before the appointment. I understand that I will be held responsible for any appointment that is not cancelled within more than 24 hours' notice. I also understand that my insurance company will not pay for missed appointments and that I must pay $25 for each late missed/canceled/rescheduled appointment.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date _____