Susan R. Nate, LPC, PhD
Board Certified Psychotherapist
WY License #486
UT License #7841141-6004

Choices for Change Counseling

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FINANCIAL AGREEMENT FORM

As a condition of your treatment by this office, financial arrangements **must be made in advance**. The following is an explanation of our Financial Policy and Agreement, which you must read and sign prior to any current and future treatment in this facility. The content of this document may not be changed.

1. Payment is expected when services are rendered.	________ Initials
2. Payment of all insurance co-payments and deductibles are required at the time of service. If you do not have insurance, you are required to pay 100% of service. If this is impossible, payment arrangements must be made with our office prior to any service. We accept cash, checks and major credit cards.	________ Initials
3. ***YOU ARE RESPONSIBLE*** for knowing your insurance plan as well as the benefits paid under your plan and the providers and network(s) covered. Any service provided but not covered by your insurance company will be your responsibility to pay. Your insurance policy is a contract between you and your insurance company. Choices for Change Counseling is not party to that contract. As a courtesy, this office will submit bills and/or assist in preparing insurance forms to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to this office. This office cannot render services on the assumption that our charges will be paid in full by an insurance company and, therefore, **your bill is your responsibility whether your insurance company pays or not**. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim. You authorize direct payment to Choices for Change Counseling of any insurance benefit. You agree to pay any unpaid balances on my account no more than 30 days after date of service.	________ Initials
4. Payment is due 30 days from the date of the invoice, unless otherwise indicated above. A $35.00 fee will be charged on all returned checks.	________ Initials
5. A finance charge of 1.5% per month (18% per annum) will be added to any outstanding payment amount on your account that is more than 30 days past due, with a minimum charge of $0.50 per month.	________ Initials
6. If an account goes past due 90 days or more, it will be turned over for collection. Should collection become necessary, the responsible party agrees to pay an additional 33.33% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs.	________ Initials
5. I grant permission to telephone me at home or at my workplace to discuss matters on this form.	________ Initials
6. I authorize assignment or payment of all mental health benefits to which other family members or I are entitled (including private insurance and other group health plan benefits otherwise payable to the undersigned to Dr. Susan R. Nate, L.L.C.).	________ Initials
7. Appointments ***MUST BE CANCELED 24 HOURS IN ADVANCE*** or I will be billed for the missed appointment. ***I WILL BE PERSONALLY RESPONSIBLE FOR MISSED APPOINTMENT FEES***.	________ Initials

ASSIGNMENT OF INSURANCE BENEFITS:

I certify that I have read this document and am the patient or am duly authorized to execute it and accept its terms. I hereby agree to abide by the conditions outlined hereon.

________________________ Please Print Patient's Name

________________________ Signature of Responsible Party

________________________ Date