THE THUSONG
A Place of Help

Financial Agreement

I have discussed and agreed to the following financial payment plan and clinic procedures with my therapist:

Payment Plan

Plan A: (Private Pay and/or co-payments) ___________________
I agree to pay $______ per session. Payment is expected at the end of each session, unless I have made prior arrangements with my therapist.
Date: ________________ Client Signature: ___________________

Plan B: (Insurance) ______________
Primary Insurance Company _________________________________
Phone# ___________________ Policy/ID# _____________________
Group/Plan# ___________________________
Policy Holder ____
DOB: ____________________ Employer

*Used Insurance for any past or previous therapy/counseling services? __________

** Please provide the receptionist or your therapist with a copy of your insurance card.

I understand that I have a co-pay of ____________ per session and/or a deductible of ________________. I agree to make these payments at the end of each session. I understand that I have a limit of _____ visits per year by my insurance company.

I authorize the release of any medical information necessary to bill insurance claims. I permit a copy of this authorization to be used in place of the original.

Date: __________ Client Signature: ________________________

I herby authorize Merlene Blair-Brown to apply for benefits on my behalf for covered services rendered by this office. I request that payments from my insurance be made directly to Merlene Blair-Brown. I understand that I am financially responsible for any unpaid balance by the insurance company within sixty (60) days of the date of service. I certify that the information I have reported with regard to my insurance is accurate. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time by written request.

Date: _________ Client Signature: ________________________

CANCELLATION/RETURNED CHECK POLICY

I understand that ALL appointments not cancelled 24 hours in advance will be charged to my account for a fee of $30/per session and must be paid at the next session. I understand that ALL appointments not cancelled prior to or during the appointment time will be charged to my account at the therapist's full fee of $125.00 per session and must be paid at the next session. I understand that if I do not show up for an appointment and do not call within 48 hours after my appointment time, I will lose my standing appointment time slot. I understand that a $35.00 service charge will be added to all returned checks and must be paid at the next session.

Date: _________ Client Signature: _________________________

I have explained the financial agreement to the above named client(s).

Date: _________ Therapist Signature: ______________________