

Financial Agreement

This Financial Agreement, dated effective _____ (this “Agreement”), is made and entered into by and among Maggie E. Roney M.S., NCC, LPC (the “Company”) and _____ (the “Client”).

Company is committed to providing caring and professional mental health care to all of Company’s clients. As part of the delivery of mental health services, Company has established a financial policy describing payment terms and options to Client.

Client’s insurance policy, if any, is strictly a contract between Client and Client’s insurance company. Company is not a party to the contract between Client and Client’s insurance company.

Client is financially responsible for payment of all services rendered, regardless of whether Client has insurance coverage. Company will bill Client’s insurance and other third-party payers for the services provided to Client, however Company does not guarantee the existence of any insurance benefits. Company is not responsible for charges that Client’s insurer(s) or other third-party payers may consider unreasonable or unnecessary. In the event that services are not covered by Client’s insurance or third-party payers, Client is responsible for any payment(s) due. Client is required to pay all billed amounts that remain unpaid by insurance companies or third-party payers after 60 days. Payments not received after 120 days are subject to collections.

Insurance deductibles and co-payments are due and must be paid at time of service. Although it is possible that Client’s mental health coverage deductible amount(s) may have been met elsewhere (e.g. if there were previous visits to another mental health provider since January of current year that were prior to first session with Company), the deductible amount will still be collected until Client’s insurance company or third-party provider verifies that the deductible amount has been satisfied.

All insurance benefits for services rendered will be assigned to Company unless Client pays the entire balance due at the time services are rendered.

Client is responsible for payment at the time of services. Parent or guardian of a minor presenting for services is responsible for payments for the minor at the time of service. Minors not accompanied by a parent or guardian will be denied non-emergency service unless payments have been preauthorized to an approved credit plan or credit card, or unless full payment is made at the time services are rendered. Client may pay by check, cash, MasterCard, or Visa. Client may elect to enroll in an automatic payment program by completing the Automatic Payment Program document.

Client will be charged \$75.00 for missed appointments or cancellations without advance notice of no less than 24 hours prior to the scheduled appointment time.

I have read, understand, and agree to the financial policy.

Client (Parent/Guardian if Minor)

Signature Date

Name of Client Printed



Financial Policy

Automated Payment Agreement

I hereby authorize Maggie E. Roney M.S., NCC, LPC to charge this credit card for payment of all amounts due, including, but not limited to, normal counseling sessions and emergency sessions, missed or cancellation appointment fees.

PLEASE NOTE: If you do not supply card information then full amount is due at time of session.

Type of card: Master Card Visa American Express

Name that appears on card: _____

Credit Card Number: _____

Exp. Date: _____ Security Code: _____

Zip Code of Billing Address: _____

Client (Parent/Guardian if Minor)

Signature Date

Name of Client Printed

Insurance Information

Insurance Provider: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Group Number: _____

ID or Policy Number: _____

Insurance Phone Number: _____

Please note: It is the client's responsibility to contact insurance provider to obtain coverage information.