Top Level Counseling and Testing Center Informed Consent and Payment Agreement for Services

Dear Client:

Welcome to our clinic. We are looking forward to working with you. The following policy statement will help clarify your responsibility in regard to the development of your treatment plan, billing, and insurance.

In regards to insurance, it will be your responsibility to call your insurance company to verify your benefits. You agree that you are responsible for the charges for services provided by this therapist to you, although other insurance carriers may make payments on your account. You understand insurance deductibles, co-payments, or full-fee for services are due at time of services.

You further guarantee that charges for services provided will be paid upon receipt of billing statements from (Top Level Counseling and Testing Center) and that the balance will be paid in full unless special arrangements are made for alternative payment scheduling. If such alternative arrangements are made, you guarantee that payment will be made in compliance with those arrangements. You understand that this office will bill insurance companies and other third party payers, but cannot guarantee such benefits, and is not responsible for collection of such payments.

There will be a charge for all appointments that are missed or cancelled without a twenty-four (24) hour notice. Insurance carriers will not pay for missed or cancelled appointments.

Informed Consent

You have been provided with specific, complete, and accurate information about:

1. The benefits and methods of treatment.
2. Options to proposed treatments.
3. Consequences of not receiving proper treatment.
4. The voluntary nature of the proposed treatment.
5. The tentative treatment plan.
6. The client rights, confidentiality, and grievance procedure.

This informed consent is effective until treatment is terminated.

Payment (Fee) Agreement

I, ____________________________ , request that the therapist/agency named above provide professional services to me and I agree to pay fee(s) of:

$ ________________ per session for individual therapy.

$ ________________ per session for family/marital therapy.

$ ________________ per session for group therapy.

I agree to pay a minimum of $_________________ of the professional fees at each session.

I have read the client's rights form and reviewed the fee schedule. In signing this form, I understand my rights as a client at this agency and responsibilities for payment.

Client/Guardian's Name: _________________ Signature: _________________ Date: ____/____/____

Top Level Counseling and Testing Center Representative: _________________ Date: ____/____/____