CANTERBURY COUNSELING CENTER
FINANCIAL INFORMATION

The standard fee for individuals, couples or family sessions is $105. Initial consultation is $130.00. Any adjustments to this fee amount must be arranged with your counselor.

Unless arrangements are made prior to your appointment, payment will be expected on the date of the appointment.

Your insurance policy is a contract between you, your employer and the insurance company. If you are planning to file for reimbursement from your insurance company yourself, please inform your counselor or the office manager.

NOTE: It is the client's responsibility to check his/her policy or contact your insurance/EAP company to know how your plan covers mental health services. This includes preauthorization for sessions.

PLEASE NOTE:
If your company denies your claim, or you have not met your deductible, you will be required to pay the balance.
***Co-pays are expected to be paid at each session if your insurance plan requires one.**

NOTE:
Please inquire IF your therapist accepts credit or debit cards.

***Returned checks** will be charged back to your account along with a $5 NSF fee.

You may choose **not to file insurance and self pay.** The amount of the session will be determined by your income. Please speak with your counselor about this arrangement.

☐ **I choose to Self Pay - Fee $_____**

It has been our experience that responsibility to this Financial Policy can become a valuable contribution to the therapeutic process.

Please sign to confirm you have read and understand all the above policies:

_____
Client's Signature

_____
Counselor's Signature

Date _____

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DECLARATION OF AGREEMENT REGARDING MISSED OR CANCELLED APPOINTMENTS

I understand and agree to the following:

1. It is my responsibility to notify my therapist or the office manager **24 hours prior to the scheduled appointment time if I am unable to keep my appointment.** I will leave a message on CCC voice mail after hours if necessary.

2. At the discretion of my therapist, I agree that **I will be billed my insurance or EAP company's contracted rate or the agreed upon fee in the event that, I fail to cancel 24 hours prior to the appointment.**

_____ _____
Client's Signature *Date*

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INSURANCE INFORMATION:

Client's Name: _____

Insurance/EAP Company Name: _____

☐ Primary ☐ Secondary

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Fill out below if CLIENT IS NOT primary on insurance:

Primary Insured's Name: _____

Insured's Address: _____

_____

Insured's Telephone Number: _____ DOB: _____

Insured's Social Security Number: _____ Gender: M F

Insured's Employer: _____

ALL CLIENTS OR AUTHORIZED PERSONS PLEASE READ AND SIGN:

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the release of any medical information necessary to process this claim.

_____ Date _____

Client's or authorized person's signature

ASSIGNMENT OF BENEFITS:

I authorize payment of medical benefits for services rendered by the rendering therapist

_____ Date _____

Client or authorized person's signature

Click Here to Print this Form and Take it with you to the Office

Click Here To Clear The Form