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 or front office staff.

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

NOTE: It is the client's responsibility to check his/her policy or contact your insurance company to know how your plan covers routine 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.**

Please ask if your therapist accepts debit or credit cards.
***Returned checks will be charged back to your account along with a $5 NSF fee**.

You may choose **not to file insurance and to self-pay.** The amount of the session will be determined by your income. Please speak with your counselor or front office staff 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:

_____ **Date**_____
Client's Signature

_____**Date**_____
Counselor's Signature

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INSURANCE OR EAP INFORMATION:

Client's Name: _____

Insurance or EAP Company Name: _____

Primary or Secondary (circle one)

Relation to Insured (circle one) 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:

1. **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

2. ASSIGNMENT OF BENEFITS:

I authorize payment of medical benefits for services rendered by my therapist.

_____ Date _____

Client or authorized person's signature