Find Peace, Even In The Toughest Situations

Christian Psychotherapy Services

Financial Agreement

This is agreement is between Christian Psychotherapy Services and myself. My relationship with my insurance company is between my insurance company and myself. Christian Psychotherapy Services files claims with some insurance companies as a courtesy. The responsibility for payment of services remains mine and I agree to pay for those services if the insurance company denies the claim or fails to pay within 90 days of service.

I hereby assign all of my rights to benefits payable by my insurance company to Christian Psychotherapy Services and hereby authorize and request my insurance company to pay my benefits directly to Christian Psychotherapy Services.

I hereby authorize Christian Psychotherapy Services to release to my insurance company, its representatives, or assigns, any information regarding my treatment. This information may include, but not be limited to, diagnoses that are necessary to process my insurance claim.

All insurance, address, and financial responsibility information necessary for collection has been provided completely and to the best of my knowledge to Christian Psychotherapy Services. I understand that any health insurance coverage, including an HMO, PPO, or any other plan that covers my care must be provided to Christian Psychotherapy Services before service is provided. Failure to provide any insurance information may require that all charges for that care will be my responsibility and that I will have to submit claims with the insurance company after I have paid for all charges.

I understand my co-payment and deductible are due at the time services are rendered. I will be billed for appointments not canceled 24 hours before the scheduled time as allowed by my insurance plan. I understand that I am responsible for all charges incurred during the course of treatment, including any psychological testing or other services not previously stated.

I agree to pay interest at the rate of 33% simple interest per annum on any unpaid balance if the matter is referred for collection. I also agree to be responsible for any costs of collection incurred by Christian Psychotherapy Services to collect a debt.

Name of Patient _____

Name of Parent or Guardian _____

Signature of Patient / Parent / Guardian _____ Date _____

Rev 20190801