S. Andrea Barrow, MS, LPC
Brittany Beers, MS, LPC
Teresa Villbrandt, MA, LPC

Financial Responsibility and Release Form

I, ____, confirm that I am the individual/entity assuming fully financial responsibility for all services provided to the following client:

Client Name: ____

Date of Birth: ____

Client Social Security Number: ____________________________

Charges for services provided by Kissel Hill Counseling Associates, LLC cover initial assessment and outpatient therapy services. We require payment of the client's copay and/or deductible amount, if applicable, at the time of the service. If you are unable to pay this amount in full, at the time of service, a $15.00 service charge will be added to the client's account and an invoice will be provided to you for the full amount due. Payment on this invoice is due within 15 days of the date of service.

Most claims will be submitted to the client's insurance carrier within one week of receiving complete billing information. The client will be notified by his/her insurance company when final action (payment, denial, etc.) for the claim has been processed. If any additional funds are owed, you will be invoiced for the full remaining balance due. Payment in full is due within 15 days of the date printed on the invoice. A service charge of $40.00 will be added to the client's account for any returned checks due to insufficient funds and/or stop payment. In the event that a past due account is submitted to a collection agency, you agree to reimburse us for the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts. In addition, please note that insurance carriers will not provide payment for no-show/late cancellation fees accrued, the financially responsible party will be responsible for the $70.00 fee assessed for appointments missed due to a no-show, and the $50.00 fee assessed for appointments cancelled or rescheduled with less than 24 hours notice of the originally scheduled appointment.

We file the insurance claim for the client as a courtesy for the client; however, our relationship is with the client, not the insurance company. It is the client's responsibility, or in the case of a minor, it is the parent/guardian's responsibility, to be knowledgeable regarding the insurance coverage and benefits. We expect full cooperation from the client, and responsible party, in obtaining payment from the insurance company. If difficulties arise that go unresolved for 60 days, the balance on the claim, with certain exceptions, will become your responsibility to pay in full. An invoice will be provided to you, and payment will be due within 15 days of the day printed on the invoice.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment to Kissel Hill Counseling Associates, LLC of any medical and/or procedural insurance benefits otherwise payable to me or on my behalf for the service(s) performed at the office, at a rate not to exceed the office's standard charges. This assignment of benefits is valid for all insurance companies and programs, including Medical Assistance, private and group insurance, employee assistance programs, workers' compensation or other health plan payments. I agree to pay any balance left unpaid by my insurance, and notify Kissel Hill Counseling Associates, LLC of any changes in my insurance information immediately as they occur.

______________________________	______________________________	____________________
Signature of Financially Responsible Person	Printed Name Fin. Resp. Person	Date Signed
______________________________	______________________________	____________________
Fin. Resp. Relationship to Client	Fin. Resp. Social Security Number	Fin. Resp. Date of Birth
______________________________	______________________________	____________________
Clinician Signature	Printed Clinician Name	Date Signed