

FINANCIAL AGREEMENT

FOR OFFICE USE ONLY

Site: _____ Dx: _____

PAYMENT OPTIONS

- Personal/Self Pay:** I understand that I am financially responsible for payment of all services rendered except for services covered by other funding sources; that payments are due and payable at the time of service unless otherwise arranged with Dr. Larson and that my personal/self pay charges may be discounted based on gross family income and number of dependents. Monthly income: _____ Dependents: _____ Set fee per visit: \$ _____
- Employee Assistance Plans (EAPs):** I understand this is a benefit which generally does not require any financial obligation on the employee's part. I acknowledge my responsibility to ensure authorization requirements have been met for my specific EAP and understand I may be financially responsible for services rendered if such procedures are not followed. I acknowledge that my EAP may or may not cover charges for no-shows or late cancellations.
- Insurance:** I understand that I am ultimately responsible for payment of all services rendered and that Dr. Larson is billing my insurance as a courtesy. **I understand it is my responsibility to ensure I have insurance benefits and that authorization requirements have been met to utilize Dr. Larson's services.**
I understand my insurance will be billed at the standard fee and that I am financially responsible for any co-payments and other charges not covered, unless otherwise contracted.
I understand that my estimated responsibility is due at the time service is rendered. Insurance deductibles will be collected at the first appointment. Pay per visit: \$ _____

(Please be complete. Missing or inaccurate information can result in payment denial by the insurance company.)

PRIMARY INSURANCE

Authorization / Referral / Kit #: _____

Ins Company Name: _____ Claims Phone: () _____
Claims Address*: _____ Policy/ID #: _____
City, State & ZIP: _____ Group #: _____
Subscriber Name: _____ Phone: () _____
Relationship: _____ Social Sec. #: _____ DOB: / / Sex: M / F
Employer: _____ Plan Name: _____

SECONDARY INSURANCE

Authorization / Referral / Kit #: _____

Ins Company Name: _____ Claims Phone: () _____
Claims Address*: _____ Policy #: _____
City, State & ZIP: _____ Group #: _____
Subscriber Name: _____ Phone: () _____
Relationship: _____ Social Sec. #: _____ DOB: / / Sex: M / F
Employer: _____ Plan Name: _____

PLEASE SEE REVERSE

**Insurance and most third party payors will not cover no-show fees.
If you no-show or cancel an appointment with less than 24 hours
notice, you will be charged the full established rate.**

STANDARD FEES

The standard fees range from \$125 to \$150 per session depending on the type of service provided.
Personal/self pay charges may be discounted based on gross family income and number of dependents.
Payment for each session, including insurance co-payment, is due at the time of service.
All checks should be made payable to Vashon Lutheran Church (VLC).

SIGNATURE ON FILE

I understand the terms, including the fees for counseling services by Dr. Larson/VLC. I authorize Dr. Larson/VLC to bill my insurance or other third party payor and to act as my agent in helping me obtain their payment. I authorize my insurance company(s) and other third party payors to make payment directly to Vashon Lutheran Church. I authorize use of this form on all insurance submissions and a copy of this authorization to be used in place of the original.

I hereby authorize Dr. Larson/VLC to release such information about services received as may be necessary for payment of my counseling bills. This may include diagnostic information about my mental health evaluation and treatment.

I understand I am responsible for my bill, that Dr. Larson/VLC is billing my insurance(s) or third party payors as a courtesy, and that I remain responsible for any amount left unpaid. If I leave therapy with an unpaid balance, I understand that Dr. Larson/VLC will make every effort to collect these debts, which may include referral to a collection agency.

I understand that in cases of divorce/separation, the person whose signature appears below accepts financial responsibility for services provided. Pursuit of payment from other parties, whether through custody arrangement or court ordered support, is my personal responsibility.

I certify that the information I have provided is correct and agree to inform my therapist of any changes in gross income and circumstances. I realize that payment is due at the time of service and that a \$15 fee will be charged on all returned checks.

SIGNATURES – Please sign both below (*)

Client or Parent/Guardian*: _____ Date: _____

Financially Responsible Party (Client)*: _____ Date: _____

Therapist: Jeff Larson, Ph.D. _____ Date: _____