KATHRINE ANDERSON
COUNSELING
MENTAL AND BEHAVIORAL HEALTH SERVICES

Kathrine Anderson, MA, LPC
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Financial/Insurance Agreement and Release

Below are the terms of agreement regarding payment for therapy sessions or services with Kathrine Anderson, MA, LPC:

1. Session fees are based on a clinical hour, which is 50-minutes, unless otherwise specified by the insurance company.
2. Session fees and/or co-pays must be paid at the time services are rendered.
3. I understand that if I am late to a session, the session will end at the originally scheduled time. It is my responsibility to arrive on time.
4. If I fail to appear for an appointment without 24-hour notice of cancellation, a missed appointment fee of $75 will be charged to the credit card on file and I will be responsible for payment. *Medicaid Clients are exempt from a missed appointment fee due to Colorado State Law.*
5. Services including phone calls, emails, record reviews, professional consults, or crisis response- at times other than the scheduled therapy session are also Client responsibility. These services will be billed at a rate of $3/minute.
6. I hereby authorize the release of Protected Health Information relating to all claims for benefits submitted for me or my dependents to the insurance company indicated below. I further agree and acknowledge that my signature on this document authorizes Kathrine Anderson Counseling to submit claims for payment of services rendered without obtaining my signature for every claim and that I will be bound by this signature as though I had personally signed each claim.
7. I hereby authorize the insurance company indicated below and hereby assign directly to Kathrine Anderson Counseling all benefits, if any, otherwise payable to me for services as described on the Financial Responsibility and Financial Agreement forms. I further acknowledge that any insurance benefits paid to Kathrine Anderson, MA, LPC, NCC will be credited to my account in accordance with the above assignment.
8. I understand that I am responsible for all session fees and/ or services if my insurance company declines payment for any reason and that the credit card provided below will be charged should this happen.
9. After 3 months, if I do not pay the amount due on my account, I give Kathrine Anderson, MA, LPC, NCC permission to release the necessary records of treatment for the sole purpose of seeking payment. I understand and agree that if I do not pay the amount due on my account within 3 months of the service date or without making a payment arrangement, I am responsible for interest, late fees, collection fees, attorney fees, court costs, or any additional costs necessary to collect the amount due on my account. If I attempt to challenge fees charged, then I forgo my right to confidentiality and give Kathrine Anderson the right to submit documents that prove fees charged were accurate and agreed upon.

INSURANCE INFORMATION

Client name: _____ DOB: _____/_____/_____

Policy owner name: _____ DOB: _____/_____/_____

Address: _____

Phone: _____ Employer: _____

Insurance Company: _____ Copay/Co-insurance: _____

Policy #: _____ Group #: _____

CREDIT CARD INFORMATION

Credit Card Company: _____ Name on card: _____

Card number: _____ Exp. Date: _____/_____ CVV_____

Billing address: _____Zip: _____

Administrative and Billing-Authorization for Release of Information

I authorize Kathrine Anderson, MA, LPC, NCC, to release information concerning me, to the administrative and billing professional at Kathrine Anderson Counseling. The disclosure of information and records is required for billing and administrative purposes. The type(s) of information to be disclosed are client personal information, insurance information, diagnosis, presence in treatment and dates and times seen, as well as anything else necessary to bill for services and perform administrative duties. I understand that this billing and administrative professional will have access to my file for the above purposes. *Without expressed revocation, this consent is valid until 3 years from now.* A photocopy of this authorization shall be considered valid. The information disclosed and/or requested shall not be used for any purpose other than its intended use. I understand that I have the right to revoke this release. I understand that once the information is disclosed, it may no longer be protected. I hereby release Kathrine Anderson, MA, LPC, NCC from liability that may result from furnishing this information.

I, _____, have read and reviewed the Financial/Insurance Agreement and I understand and voluntarily agree to ALL contingencies and ROI's presented above.

_____ _____

Signature of Client or Responsible Party Date