IMARA
COUNSELING SERVICES

## FINANCIAL DISCLOSURE - INSURANCE

**Primary Insurance Company** _____ **Phone #**_____

**Policy/Member ID#**_____ **Group/Plan#**_____

**Policy Holder**_____ **DOB:**_____

I authorize the release of any medical information necessary to bill insurance claims. I permit a copy of this authorization to be used in place of the original.

**Client Signature:**_____ **Date:**_____

Our office is pleased to accept your insurance assignment. After verification of coverage we will file your claim forms and assist you in every way we can. However, it must be fully understood that the contract is between YOU and your insurance company, and you are fully responsible for any amount not paid by your insurance company. Our office does not guarantee that your insurance company will pay. We will make every attempt to verify your insurance coverage.

However, if your insurance claim is for some reason denied, you are responsible for the full amount of the bill. We will not begin a dispute with your insurance company over your claim. That is your responsibility and obligation. I hereby authorize Imara Counseling Services, LLC to apply for benefits on my behalf for covered services rendered by this office. I request that payments from my insurance be made directly to Imara Counseling Services, LLC. Should an insurance payment inadvertently be sent to me, I will endorse it and return it to Imara Counseling Services, Attn: Billing Department immediately. I understand that the card I have put on file may be charged for any balance unpaid by the insurance company, including deductibles and coinsurance that is unpaid. I certify that the information I have reported with regard to my insurance is accurate.

I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time by form of written request.

**Client Signature:** _____ **Date:** _____

I agree to pay copays and any unmet deductible at the time of my appointment. I understand that I must have a card on file in order to hold appointments with my therapist. I understand that if I request my therapist to write a report outside of a regular session time, I will be billed according to the amount of time the report takes my therapist to write. For example, if the report takes the therapist thirty minutes and their hourly fee is $130, then the report will cost $65.

I also understand that if I request my therapist to consult with teachers, principals, other doctors, social workers, attorneys and/or any other professionals, there will be a charge for the therapist's time required for the consultation. I agree to prepay for this service with cash or a check when it is requested, or I agree for my therapist to charge my card on file at the time of the consultation and/or report writing service.

I understand that all appointments not cancelled 24 hours in advance will be charged at the full therapist's rate for the time reserved for the session to my credit or debit card on file. I understand that this

is not the amount of the copay, but rather this is the full amount that the insurance would reimburse my therapist for if I were to have attended the missed appointment. Although my therapist understands that there will likely be times when I may need to cancel an appointment, that this time has still been set aside only for me and I am still responsible for the session fee because the therapist likely will not be able to fill that scheduled time with an alternative client.

I understand that a $25 service charge will be added to all returned checks and the fee will be charged to my card on file. I agree to pay all reasonable collection or legal fees should Imara Counseling Services, LLC need to use an outside collection agency or legal means to collect on this account. Balances older than 30 days may be subject to additional late fees and interest charges of 10% per month. The undersigned will be responsible for all costs incurred in the collections of any past due account, including attorney's fees.

I understand and agree with all of the above.

**Client Signature:** _____ **Date:** _____

I have explained the financial agreement to the above named client(s).

**Therapist Signature:** _____ **Date:** _____


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