Kelly Ferraro **LPC, PLLC**

FINANCIAL AGREEMENT

Client Information
Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone (specify if work or cell):_____

Employment: ▫ Employed ▫ Full-time Student Gender: ▫ Male
▫ Part-time Student ▫ Other specify_____ ▫ Female

Name of Employer: _____ Employer Phone: _____

Employer Address: _____ City: _____ State: _____Zip: _____

Insurance Information
Name of Person Responsible for Bill: _____Date of Birth: _____

Relationship to the client: _____

Address (if different): _____

Home Phone: _____ Alternate Phone (specify if work or cell):_____

Name of Employer: _____ Employer Phone: _____

Employer Address: _____ City: State: Zip: _____

Primary Insurance Information
Name of Insurance Company: _____ Policy #: _____

Policy Holder Name: _____

Relationship to Insured member: _____Co-pay amount: _____

Insurance Company Phone: _____ Effective Date: _____

Do you have a calendar year deductible? Yes __ No____

If so, how much have you met? _____

Agreement
I understand that I am responsible for contacting my insurance company to verify and my insurance coverage. I agree to obtain pre authorization for counseling services, if my insurance company requires me to do so. Please be aware, that receiving authorization for services does not guarantee that your insurance company will cover the services you are receiving from Kelly Ferraro LPC, PLLC. Your insurance company will determine if these charges will be covered at the time the claim is received. *I understand that I am ultimately responsible for payment of my bill regardless of insurance.*

I agree to update my therapist regarding any changes with my insurance coverage and allow my therapist to maintain a copy of my current insurance card. I authorize Kelly Ferraro LPC, PLLC or my insurance company to release any confidential information required to bill and be paid for services. Furthermore, I authorize payment directly to my therapist and hereby assign my right to reimbursement to Kelly Ferraro LPC, PLLC.

Additionally, I agree to pay at the time of service all fees due, including insurance deductibles, insurance co-payments, late cancellation/missed appointment fees or any charges for returned checks.

I will:
____Pay each visit in full and file my own insurance
____Pay my insurance co-payments and any other fees each session and have my insurance billed
____Self-pay
____ I will be using my EAP

I have read the above, understand, and accept the policies described herein. I certify that the above information is complete and accurate and understand all information is subject to verification by Kelly Ferraro LPC, PLLC.

_____ _____
Signature of client (or person acting for client) Date

_____
Printed name

I, Kelly Ferraro, LPC, PLLC, have discussed the issues above with the client.

_____ _____
Signature of therapist Date

____ Copy given to client ___ Copy kept by therapist