DIAKONOS COUNSELING
FINANCIAL RESPONSIBILITY STATEMENT AND CONTRACT

CLIENT'S NAME: _____
RESPONSIBLE PARTY FOR PAYMENT: _____

THE BENEFITS BELOW WERE QUOTED TO DIAKONOS BY YOUR INSURANCE COMPANY. YOU ARE FINANCIALLY RESPONSIBLE FOR ANY FEES THAT YOUR INSURANCE COMPANY DOES NOT COVER.

STANDARD FEE: $195 INITIAL EVALUATION/ $140 55 MIN SESSION
SLIDING SCALE FEE (IF APPLICABLE) $_____

INSURANCE DEDUCTIBLE _____ CLIENT CO-PAYMENT _____%
INSURANCE CO-PAYMENT _____ % OF REASONABLE & CUSTOMARY CHARGE
NUMBER OF COVERED SESSIONS ALLOWED PER YEAR _____

I understand and agree that…

1. I am responsible for the charges I incur as a result of counseling, therapy, consultation, assessment, or other services rendered.
2. Charges are based on the amount of professional time used.
3. A minimum late cancellation charge/no show charge of $75 may be billed if I do not notify the office 24 hours prior to my appointment. Additional late cancellations/no shows may be billed up to the full session fee. This charge will be billed to me directly rather than the insurance company.
4. All payments are due at the time services are rendered unless other arrangements have been made in advance. I agree that these charges may be automatically charged by Diakonos using a designated debit, credit, or HSA card.
5. I will be responsible for paying the full amount of fees which are not covered by insurance or other 3rd party payers.
6. It is my responsibility to know what my deductible is and the percentage at which my insurance reimburses fees for counseling. Diakonos will call and check with my insurance company regarding these items as a courtesy to me. The figures given to Diakonos are not guaranteed to be the coverage benefits otherwise payable to me. Diakonos is not responsible for information given in error by the insurance company.
7. I authorize payment directly to Diakonos of the coverage benefits otherwise payable to me.
8. I authorize the release of any medical information necessary to process this claim. This information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I may revoke this consent at any time by providing written notice.
9. I will notify Diakonos of any changes in my insurance or in my financial situation.
10. I will notify Diakonos of any changes in my address and/or telephone number.
11. Should my account become more than 120 days delinquent, it may be turned over to a collection agency.

My signature below acknowledges that I agree to all of the above terms and consent to treatment at Diakonos Counseling. If applicable, my signature also indicates that I am signing for a minor child named above.

_____
Signature (Client or Guardian of Client) Date

_____
Signature (Person responsible for payment) Date