Family Service Agency
Strengthening Individuals & Families

Financial Information

Name of Client: Last_____ First_____ MI_____ Birth Date_____

SSN_____ Phone: Cell_____ Home_____ Work_____

Address _____City_____ State _____ Zip _____

Person Insured: Last_____ First_____ MI_____ Birth Date _____

SSN_____ Phone: Cell_____ Home_____ Work_____

Address _____City_____ State _____ Zip _____

Employer of Person Insured _____

Responsible Party (if not the client**):** Last_____ First_____ MI____ Birth Date _____

SSN_____ Phone: Cell_____ Home_____ Work_____

Address _____City_____ State _____ Zip _____

Any and all insurance: _____

Primary Guardian: _____ **Secondary Guardian:** _____

Custody Arrangement Married Joint Custody Shared Custody No arrangement (Never married)
Circle one
No arrangement (Divorced) Other: _____

Household size: _____ **Household income: _____**

Agreement To Pay For Professional Services

I agree to pay the fee of up to $150 per session for these services and additional fees described below or to pay the fee negotiated by the insurance company, Employee Assistance Program, employer, financial assistance scholarship or other third party payer.

Additional charges may apply:

- The fee for intake or diagnostic assessment is $150.
- Sessions extended more than 10 minutes are charged on a pro-rated basis for the additional time.
- If I seek additional services (i.e. requesting materials for court, seeking a counselor in court) I will be charged the hourly rate of $90 for those services.
- The fee for mediation is $125 per hour which is divided equally between each party.
- The fee for phone consultation with a counselor is pro-rated based on the hourly rate of $90.
- The fee for checks returned for insufficient funds is $25 per occurrence, plus any applicable collection fees.
- If I fail to cancel an appointment less than 24 hours in advance or no show I will be charged a $25 fee.

Additional billing policies:

- I am responsible for knowing my insurance benefits and for providing accurate and timely insurance information, including completion of any authorization or approval process required by my insurance company. Any fees not covered by my insurance company resulting from not knowing benefits or providing accurate or timely information is my responsibility.
- There are some services that insurance may not cover and I am responsible for these fees or any fees denied for coverage by my insurance.
- If my insurance or other third party payer has not paid for services after two billings or denies coverage, I am fully responsible for the remaining bill for services.
- If a bill is not paid it may be sent to collections and I will be responsible for the additional 35% charged by the collection agency to collect the bill.
- I am responsible to give the Family Service Agency updated address information. Failure to do so may result in any unpaid bill being sent to collections.
- Lack of payment of the co-pay for two consecutive sessions or lack of timely payment on a pre-arranged payment plan may result in being unable to schedule another appointment with a counselor until payment is received on the account.
- Any billing questions should be directed to the Family Service Agency Business Office.
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I understand and agree to abide by the policies contained in this Agreement to Pay for Professional Services. If applicable, my signature below authorizes my insurance to make payment directly to Family Service Agency's Center for Counseling.

_____ _____

Client Signature Date

_____ _____

Signature of Responsible Party (if other than client) Date

_____ _____

Witness Date