Canterbury Counseling Center

CANCELLATION POLICY

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I understand and agree to the following:

- It is my responsibility to notify my counselor or the office staff 24-hours prior to the scheduled appointment time if I am unable to keep my appointment. I will leave a message on CCC voice mail after hours if necessary or if phone lines are busy.
- At the discretion of my therapist, I agree that I will be billed my insurance or EAP company's contracted rate or the agreed upon fee in the event that I fail to cancel 24-hours prior to the appointment.
- In the event that I do not call to cancel my appointment at least 24 hours in advance, any future scheduled appointments will be CANCELLED. I acknowledge that I may return to services paying the fee for not showing for my appointment and calling to schedule the next available appointment.

Client's Signature _____ Date: _____

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FINANCIAL AGREEMENT

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- The standard fee for individuals, couples or family sessions is $140. Initial consultation is $160.00. Any adjustments to this fee amount must be arranged with your counselor or front office staff.
- Unless arrangements are made prior to your appointment, payment will be expected on the day of service.
- Your insurance policy is a contract between you, your employer & the insurance company. If you are planning to file for reimbursement from your ins company yourself, please inform your counselor or the office staff.
- **NOTE:** It is the client's responsibility to check his/her policy or contact your insurance company to know how your plan covers routine mental health services. This includes preauthorization for sessions.
- If your company denies your claim, or you have not met your deductible, you will be required to pay the balance.

*Co-pays are expected to be paid at each session. If you do not know your co-pay amount, a $20 fee will be collected.

*Returned checks will be charged back to your account along with a $30 NSF fee.
You may choose not to file insurance and to self-pay. The amount of the session will be determined by your income. Please speak with your counselor about this arrangement. If you are participating in self-pay, the agreed upon amount is due at the beginning of each session.

It has been our experience that responsibility to Financial Policy is a valuable component of the therapeutic process.

Please sign to confirm you have read and understand all the above policies:

Client's Signature _____ Date: _____

Counselor/Staff Signature_____ Date: _____

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INSURANCE (EAP) INFORMATION

***Please note that for all non-Medicare coverage, we bill as primary insurance only. If your therapist is not in your primary insurance network, services will not be covered.**

Insurance or EAP Company Name:_____

Client's relation to Insured (circle one) Self Spouse Child Other:_____

Fill out below if client is NOT primary insurance carrier:

Primary Insured's Client Name:_____ Date of Birth:_____

Address:_____ Phone:_____

Social Security Number:_____ Gender:_____

Insured's Employer:_____

ALL CLIENTS OR AUTHORIZED PERSONS PLEASE READ AND SIGN:

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the release of any medical information necessary to process this claim.

Client's or Authorized Person's Signature:_____ Date:_____

ASSIGNMENT OF BENEFITS:

I authorize payment of medical benefits for services rendered by my therapist.

Client's or Authorized Person's Signature:_____ Date:_____