Dr. Linda Comin Psychologist Inc.
Financial Agreement

Client Information:

Last Name First Name Middle Initial

Date of Birth

Address City State Zip

Home phone Work Phone Cell Phone

Name of Person Responsible for Bill (if different from above) Relationship to Client

Date of Birth

Address City State Zip

Home Phone Work Phone Cell Phone

Will Insurance be filed? Yes______ No_____

Fee: _________

Insurance Information:

Name of Insurance Company Insurance Company Phone Number

Policy Number of Subscriber or Recipient ID#

Policy Holders Name Policy holder DOB Policy Holder SSN:

Relationship to Client

Benefit Period? From: _____________________ To: ____________________________
Do you have a deductible? Yes___ No____ If so how much?
Co-pay amount: ______________
Number of Sessions allowed by your insurance: __________

48-Hour Cancellation Policy

I require all clients to carry a credit card authorization on file to cover missed sessions or returned checks. You are financially responsible for a missed appointment, or one that is cancelled without 48-hour notice.

Name on Credit Card: ___________________________ Credit Card#_____________________________________

Expiration Date: __________________ Three digit Security Code on back of card: _______________

Client Responsibilities:

I understand that I, not my insurance company is responsible for all fees and services rendered by Dr. Linda Comin Psychologist Inc. and that payment including all deductibles, co-pays, late cancellation fees and fees for returned checks is due at the time services are rendered.

I understand that I am responsible for checking with my insurance company for verification of benefits including: coverage, deductibles, co-pays and number and types of sessions (individual therapy vs. family therapy vs. couples therapy) allowed.

I agree to keep my therapist informed of any changes in my policy or coverage.

I further understand that if I have a lapse in coverage, or the insurance company for any reason denies claims, that I am responsible for the balance on my account.

I understand that I am responsible for keeping track of the number of sessions I use during a benefit period and am responsible for notifying the therapist at least 3 weeks in advance if request for additional sessions are needed. _________(Initial here)

If I go over the allotted number of sessions in a given benefit period without having received authorization for additional session, I understand that I will be responsible for the full balance of any claims denied by the insurance. ________(Initial here)

I understand that I must provide 48 hours notice for cancellation if I need to change an appointment, and that failure to provide such notice will result in a being charged for a full session 45-minute session. This is your allotted time and if you do not show up or cancel your session that time cannot be assigned to anyone else. _________(Initial here)

I authorize Dr. Linda Comin Psychologist Inc., to release any information required for billing and collecting claims.______________(initial here)

I understand that during the course of therapy it may become necessary to increase fees to compensate for increased costs and inflation. Fees will be reviewed periodically and will be increased no more than once during a calendar year.

I certify that, to the best of my knowledge, these forms have been completed accurately and that I understand and accept my financial responsibilities.

- *I understand that therapy is a relationship and that like any relationship there is a clear beginning and ending (closure). Therefore, it is required that before ending therapy you must attend an exit session for closure to discuss the process and the takeaway from your treatment. ___________(Initial here)*

______________________________________ ________________________

Signature of client or Authorized Representative Date

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Print Name