**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-Business Hour Cancellation Policy**

**(No cancellations will be accepted on weekends)**

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 Business 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.***

**Please be advised that Dr. Linda Comin does not testify in lawsuits. Are you currently involved in litigation with someone for a wrongful act, a child custody matter or planning to be in litigation in the near future? (*Circle One*) Yes No**

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

**I authorize Dr. Linda Comin, 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, after 4 sessions, that before ending therapy I must attend an exit session for closure to discuss the process and the takeaway from my treatment. If I do not attend a final session with Dr. Linda Comin I will be charged the full session fee. \_\_\_\_\_\_\_\_\_\_\_\_(Initial here)***

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Signature of client or Authorized Representative Date

Print Name