Billing Policy

Client Information

Client's name: _____ Date of birth:_____/_____/_____
Address:
_____

Phone (H): _____ (W): _____ (C): _____

Email address: _____
Do you consent for the use of your email by Arden Shores Counseling?

Primary Insurance Information

Carrier Provider:
Phone Number:
Policy ID:
Group Number:
Policy Holder Name (if not client):
Policy Holder Date of Birth:

Billing Information and Policy

Our billing policy for services, which are the client's responsibility, is as follows:

Please be aware of the following:

- All co-pays, co-insurance, and deductible amounts are due on the date of service.
- **Cancellation Policy:** Please give a 24-hour notice if you will not be able to keep an appointment, or if you will be running late.
- Clients will not receive a statement for services that are the responsibility of their insurance company. Nor will clients receive a statement if their balance has been paid in full on each date of service, and their account is current.
- Any counseling services that are not eligible for coverage through a client's insurance plan become the responsibility of the client.
- Receipts for all credit or debit card transactions and statements will be available in your patient portal or printed by request.
- I understand that if I default on any payment obligations in this agreement, Arden Shores Counseling will have the right to forward my information to collections, and risk discontinuation of services. I understand and give my consent for Arden Shores Counseling, to forward my information to collections, should I default on this agreement and fail to pay my Balance Due.

My signature below certifies my consent to the billing and payment policy. All of my questions have been answered and the policy regarding billing is fully agreed to. I also, by signing below, consent to taking full responsibility for any outstanding bill for services rendered. I also agree that my signature authorizes Arden Shores Counseling, LLC to pursue any outstanding balance due to them should I not follow the clinic policy.

_____

Signature (Client or Legal Guardian if client is under 18) Date