PEMBERTON & YOUNG COUNSELING

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FINANCIAL AGREEMENT

As a courtesy, we will bill your insurance if you provide **valid proof of coverage** at the time of service. We will make every effort to ensure that claims are complete and accurate when submitted; however, follow up on your insurance claims is your responsibility.

You are expected to pay any/all deductibles and co-pays at the time of service and are responsible for paying any balance that is not covered by your insurance. Any date of service balance remaining after resolution of your insurance claim will be due (30) days after receipt of billing statement. We accept cash, check, and major credit cards. Billing statements and receipts will be sent electronically if an email address has been provided. Your provision of the email address shall be considered your consent to receive this information electronically.

If you fail to pay your final bill or to make financial arrangements to settle your account within thirty (30) days of receiving your statement, your account will be subject to referral to a collection agency.

The following benefits were quoted to Pemberton & Young Counseling, LLC; however, this is not a guarantee of benefits and you should contact your insurance directly to confirm. All services rendered are charged directly to you and you are personally responsible for any unpaid charges.

Date: _____ Time: _____ Prepared by: _____
Insurance Carrier: _____ Phone Number: _____
In-Network Benefits: Y / N
Patient name: _____ DOB: _____
Policy Number: _____ Group Number: _____
Calendar Year: Y / N Plan Renewal Date: _____

Individual Deductible: _____ Amount Met: _____
Family Deductible: _____ Amount Met: _____
Out of Pocket Max (OOPM): _____ OOPM Met: _____
Family OOPM: _____ Family OOPM Met: _____
Therapy coverage: _____ Limitations: _____

Estimated patient responsibility:

Name of Responsible Party [print]: _____

Signature of Responsible Party: _____ Date: _____

Relationship to the Patient: _____