Letitia D. Brown, LCSW
Caring for Our Community

CLIENT'S FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

Client Name: _____ Date: _____

Insurance Company(s): _____

Assignment of Insurance Benefits

I hereby authorize LETITIA BROWN, LCSW, CARING FOR OUR COMMUNITY to furnish to the above-mentioned insurance company(s) with requested information.

I hereby assign to LETITIA BROWN, LCSW, CARING FOR OUR COMMUNITY, all money to which I am entitled for medical expenses related to the services rendered by my therapist, but not to exceed my financial obligation. It is understood that any money received from the above-named insurance company, over & above my obligation will be refunded either to me or my insurance company when my bill is paid in full. I agree to pay my co-payment/deductible at the time of service.

Self-Pay Rates

Assessment	**Rate**
• Evaluation	$120.00
Outpatient Services	
• Individual Therapy	$95/60 min session
• Family/Marital Therapy	$110.00/60 min session
• Tele-Medicine (Therapy)	$150.00/60 min session

Please read then initial each statement below:

_____ I hereby agree it is my responsibility to advise LETITIA BROWN, LCSW, CARING FOR OUR COMMUNITY of any insurance changes in a timely manner. This will allow LETITIA BROWN, LCSW, CARING FOR OUR COMMUNITY time to obtain appropriate authorizations to be received prior to my appointment.

_____ Failure to notify LETITIA BROWN, LCSW, CARING FOR OUR COMMUNITY of insurance changes may result in a denial of services which will become your full financial responsibility.

_____ I hereby agree that I am financially responsible for all non-covered charges, at the rates listed above for Outpatient Therapy Services.

_____ I further agree, in the event of nonpayment, to bear the cost of collections and/or court cost & reasonable legal fees should this be required.