L. Chris Cannida, LPC-S, CCTP
425 E. 22nd St., Suite 103D, Owasso, OK 74055 * (918) 209-3902 * connect@chriscannida.com

Please provide information and top 2 signatures regardless of payer source for services.

FINANCIAL AGREEMENT:
Payment is due at time of service, unless other arrangements are made. I accept full financial responsibility for all charges not covered by insurance, EAP services, or other parties paying on my behalf.

CANCELLATION POLICY: Your appointment time is reserved solely for you. Late cancellations or no-shows prevent other clients from using that time. If cancellations are not made at least 24 hours prior to set appointment, the responsible party will be charged 100% of the fee allowable. ***Though reminders are given as a courtesy, they do not replace client responsibility to policy***. Insurance companies do not cover payments for missed appointments and missed EAP appointments could count toward your allotted # of authorized sessions. **Repeated cancellation or no-shows could result in termination of services.**

I acknowledge understanding of the Financial Agreement and Cancellation Policy:

X _____ _____/____/____
Signature **Date**

Insurance Information:

Billable Party: _____ **Relationship to Client**: _____

Client's Relationship to Insured: SELF SPOUSE CHILD OTHER _____

Primary Insured's Name:_____ **DOB:** __/__/____

Address: _____

Phone: _____

Primary Insured's Employer: _____

Primary Insurance: _____ _____

Primary ID/Subscriber #: _____**Group** #_____

Secondary Insurance: _____**Secondary ID/Subscriber #:** _____

Patient's, Insured's, or Authorized Person's Signature*: I hereby authorize the release of any medical or other information necessary to process all claims for the client described above. I also request and assign payment of insurance, medical, and/or government benefits to Lori Chris Cannida, MS, LPC.*

X _____ ____/____/____
Signature **Date**

For Insurance Opt-Out Only: _____ I acknowledge that L. Chris Cannida, LPC is in-network with my insurance plan(s), but am choosing to opt-out of using benefits for coverage. I understand I will be responsible for payment of all service fees and it is up to me to inform in writing should my decision change. I understand Ms. Cannida does not file claims for reimbursement out-of-network coverage, though will provide a Superbill allowing me option to file myself.

X _____ ____/____/____
Signature **Date**