SpeakLife

Counseling & Professional Development Services

Dominique Dillard, LPC, M.S.

PATIENT/RESPONSIBLE PARTY FINANCIAL AGREEMENT

Welcome!

In order to make your transition as simple as possible, below are some policies that you will need to read and sign. I look forward to serving you as a client.

*** All patients will need to bring the following items: **A CURRENT DRIVER'S LICENSE/PICTURE ID AND AN UPDATED INSURANCE CARD**. If you do not have proof of insurance, you will be expected to pay if full at the time of service. ***

1. You expect good quality service and the fees charged are comparable to those charged in our community for professional counseling services. All initial and ongoing counseling appointments are $175.00. **All co-payments and fees are due at the time of service. I accept Cash, Credit or Debit cards. NO CHECKS**

   Signature ___________________________________

2. **I am aware that I will be charged the hourly CASH rate of $175.00 for Dominique Dillard, LPC, for canceling an appointment without a 24 hour ADVANCED NOTICE or if I do not show up for my appointment. I am aware this fee is not billable to insurance and that I am responsible for the entire fee.**

   Signature ___________________________________

3. I am aware that if I have repeat cancellations and/or No Shows that my therapist has the right to terminate services due to non-compliance with treatment and care.

   Signature ___________________________________

4. Should collection proceedings become necessary, I accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees (33.33%), attorney fees and/or court costs if such be necessary.

   Signature ___________________________________

5. You agree, in order for us to service your account or to collect monies you may owe, SpeakLife Counseling and/or our agents may contact you by phone at any phone number associated with your account, including wireless phone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. I/We have read this disclosure and agree that SpeakLife Counseling and/or agents may contact me/us as described above.

   Signature ____

6. I am aware all co-payments are due at the time of service, and I understand that I am financially responsible for all charges whether or not paid by my insurance.

   Signature ________________________________

7. I am aware that authorization from my insurance company **does not** guarantee payment. I am aware that only a portion is paid by my insurance company for any assessment/evaluation/testing/psychotherapy and the balance is my responsibility. I hereby authorize the Doctors to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.
   Please know the benefits of your insurance plan. If you have a deductible which has not been met, or your insurance deems your visit as a non-covered service, you are responsible for the balance. The terms of your insurance plan are between YOU and YOUR insurance company. WE DO NOT DETERMINE YOUR BENEFITS OR PAYMENT TERMS.

   Signature ____________________________________

I have read and understand the above. If the patient is a minor, this is to be read and signed by the parent/guardian.

____ ____________________

Signature of Insured/Responsible Party Date

____ ____________________

Witness Signature (provider) Date