

Lighthouse Counseling Services, LLC
Payment Contract for Services

Name(s) of client(s) receiving services _____
Person responsible for payment (if different) _____

Federal Truth in Lending Disclosure Statement

Clients With Insurance Coverage

Some Insurance companies have incorporated your Social Security number as a part of your ID number. Please check your card to see if this is required and fill in your full ID number here.

Insurance Carrier	_____
Full ID Number	_____
Group Number	_____

Deductible amount: \$ _____

Co-payment: % or \$ _____

We suggest you confirm your benefits and eligibility with your insurance company. Your insurance company may not pay for services that they consider to be not effective, not medically or therapeutically necessary, or ineligible. You are responsible for any amount not covered by insurance. It is your responsibility to know if the desired therapist is accepted by your insurance.

Clients Without Insurance Coverage

I (we) agree to pay Lighthouse Counseling Services, LLC. a rate of \$ _____ per session (Defined as 45–60 minutes depending on the type of service rendered. Session could be for an assessment, individual, family, and/or relationship counseling).

All Clients: Please read and sign below

Payments and co-payments are due at the time of service. Any amount due on the client’s account will be issued a statement showing the balance. Statement charges are due within 15 days. There may be an interest surcharge posted to overdue accounts which will be included on the statement.

I authorize Lighthouse Counseling Services, LLC. to disclose case records (diagnosis, case notes, psychological reports, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to Lighthouse Counseling Services, LLC. I understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I understand that I may revoke this consent at any time by providing written notice, and after one year this consent expires.

By signing below, I agree that I have received, read, and agree to the conditions of this form including the Federal Truth in Lending Disclosure Statement for Professional Services.

Signature of person responsible for payment _____
Date