2356 University Ave W, Suite 280
Saint Paul, MN 55114
651-646-1488 phone
651-646-2285 fax

Family Circle Counseling

Financial Agreement

- _____ **I understand** and agree that it is my responsibility to understand my benefits for mental health services, to be aware of any co-payment, deductible, pre-authorization, or limits that apply to my plan, and to inform my therapist of these.
- _____ **I understand** that any co-payment is due at the time of service.
- _____ **If my insurance coverage** changes during the course of treatment, I agree to notify Family Circle Counseling prior to the change.
- _____ **In the event that** I fail to communicate any information regarding my insurance plan(s), co-pays, deductibles, pre-authorization or changes, I agree that I will be responsible for any charges that are denied as a result.
- _____ **I understand** that I am responsible for all charges whether or not paid by insurance. This includes amount re-claimed by insurances, whichever the date of the re-claim.
- _____ **I certify that** I (or my dependent) have insurance coverage(s) as noted in the Insurance Information and Financial Agreement form, and only these. I assign directly to Family Circle Counseling all insurance benefits, if any, otherwise payable to me for services rendered.
- _____ **I hereby authorize** Family Circle Counseling to release to my insurance carrier and to Family Circle Counseling PLLC billing services all information needed to secure the payment of benefits, and to mail client statements.
- _____ **I hereby authorize** my insurance carrier to send payments for services to Family Circle Counseling, PLLC.
- _____ **I certify** that I have read and filled out this form completely to the best of my knowledge.

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Responsible Party Signature Relationship to Client Date

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Family Circle Therapist Signature Date

I certify that the services to be billed are medically indicated and necessary to the health of this client and will be personally furnished by me and/or another Family Circle Counseling, PLLC staff.