FINANCIAL AGREEMENT for THE CENTER FOR COUNSELING & TRAINING, LLC---Please read carefully!

* I agree to pay in full all outstanding balances at the time of service. I recognize my failure to pay my account in full within 30 days after services are rendered may result in my balance being placed with a collection agency and possible listing with the credit bureaus.

*I understand my insurance claims will be sent either electronically through the computer or by regular mail to my insurance company where it will be reviewed by any insurance company staff assigned to review claims. I understand my insurance company will obtain information listed on the insurance claim about my diagnosis and the dates of my mental health treatment sessions. By my signature below, and as recorded on the HIPAA consent form, I am giving The Center for Counseling & Training permission to release all data necessary to my insurance company to determine eligibility and to process my insurance claim.

*I understand The Center for Counseling & Training will not be responsible for any split in cost of services due to a custody/parenting agreement. Because I have signed this financial agreement and the registration form, I understand I am responsible for the entire bill.

*I further agree, in order for you to service the account or to collect any amounts I may owe, you may contact me by telephone at any telephone number associated with my account including wireless telephone numbers, which could result in charges to me. You may also contact me by sending text messages or emails, using any email address I provide to you. Methods of contact may include prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree to be contacted as described above.

*I understand I MAY be charged an additional fee if my account is sent to a collection agency or to small claims court.

*Although I have requested this office to bill my insurance company on my behalf, I clearly understand it is still my responsibility to make sure the bill is paid in a reasonable time. I understand there are times when TCCT might have been told by my insurance company that my services are covered and later find out they are not. If, for any reason, any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.
Certain special services (ex: report writing, court-ordered treatment/evaluation, case management services) are often not covered by insurance. It is the client/parent/guardian's responsibility to determine what services are and are not covered by their health insurance.

*If you become involved in any legal matter that requires your therapist to testify in court for your attorney or the court, these services will not be billed to insurance as they are not mental health therapy/evaluation services. These fees are separate.

*I am aware I need to contact The Center for Counseling & Training if I will not be at my scheduled appointment. For each appointment I do not call *at least 24 hours in advance to cancel, I understand I will be billed $25.00*. This must be paid prior to me attending my next appointment. I understand if I have *3 no call/no show appointments*, my therapist can refer me/my child to another counselor for services.

*If I request a copy of my records I will be charged the rate of 52 cents per copy plus a handling fee.

*TCCT can safely & confidentially store your credit/debit card information for the purpose of paying co-pays, co-insurance costs, and/or other fees you might incur. TCCT requires you to have a credit/debit card on file. By signing this you are allowing TCCT to charge your card on file for the amount due on your account

---

I have read and understand the financial agreement as detailed above. By my signature below I agree to abide by the terms of the financial agreement, fully understand the release of information to my insurance carrier, and agree to make all efforts to pay for services rendered in a timely fashion.

_____	_____	_____
Signature	Printed Name	Date Signed