

Financial Agreement and Receipt of Privacy Policies and Informed Consent
Bethlehem Counseling Associates

Name of Client _____

Deductible: _____

Copay/Coinsurance: _____

The financial information listed above has been provided by your insurance company. Co-payments are due at the time the service is rendered. Co-insurance and deductible vary for each insurance policy and we can only approximate the percentage covered by each plan. Payment of the estimated portion is due at the time of service. If you have any questions about the stated benefits, please feel free to contact your insurance company.

Please note: If you have secondary insurance, you are responsible to pay whatever your primary insurance says is your responsibility. If your secondary insurance pays, you will be reimbursed.

I authorize Bethlehem Counseling Associates to release any information obtained during examinations or treatment, which is necessary to expedite and support any insurance claims. **I understand that I am financially responsible for all charges, regardless of insurance coverage.** I authorize the payment of benefits directly to this provider. Medicare regulations may apply.

BCA requires that co-pays for your treatment are due at the time your services are rendered. Please indicate how you plan to pay for any amount not covered by your insurance.

_____ I will keep a credit card on file at BCA for co-pays or any monies not covered by insurance. **(preferred method)**

_____ I will be paying the co-pay **at each session** in the form of cash/check/or credit card. I understand that BCA does not allow clients to carry a balance. Any exception to this must be discussed, and pre-authorized by your treating clinician. Failure to remit payment may result in your inability to schedule future appointments, and appointments scheduled may be cancelled. There is a \$35 charge for any returned checks.

_____ I have received a copy of BCA Privacy Policies and Procedures and the BCA Informed Consent to Counseling and have asked questions about anything that is not clearly understood. I agree to comply with the policies and information presented.

Client Name

Client/Responsible Party Signature

Date