Patient's Name_____

PAYMENT – INSURANCE AGREEMENT
Ebenezer Counseling Services

I accept responsibility for payment of charges for services rendered to the above named patient. I understand that full payment and/or my co-payment and/or deductibles are expected at the time services are rendered unless the doctor/therapist agrees otherwise. I understand that, unless the above named patient has coverage under a managed health plan (e.g., HMO, PPO, EAP, etc.) to which I subscribe and in which the doctor/therapist is a participating provider, I am personally responsible for the payment of all charges. I understand that, as a courtesy, the doctor/therapist will file insurance claims for the services provided, however, this does not release me of my responsibility for payment of the charges for services. Payment for any charges denied or not covered by my insurance company become my responsibility and I agree to pay these charges. I also understand that any court order I have is an agreement between myself and the courts NOT the doctor/therapist and I am still responsible for payment of all charges. I understand and agree that I may be charged for and required to pay for missed appointments not cancelled at least 24 hours in advance. I further understand and agree that a collection agency will be used in the event of delinquent payment, with the added cost of the collection agency being paid by myself, the client or responsible party for the client, and I realize that such action could require that the doctor/therapist release to the collection agency, attorneys, and/or the courts, information which identifies the parties involved, gives the patient diagnoses, and describes the dates and nature of the charges, as well as all other information contained on any claim filed. In addition, if I have requested that the doctor/therapist file the charges to my insurance company, I understand that securing benefits under health insurance or other health plans will require that the doctor/therapist provide the plan management with confidential patient information, including diagnosis and the dates and type of service rendered. Further, I understand that for utilization review, quality assurance, and other claims review purposes, it may sometimes be necessary for the doctor/therapist to provide the plan management with additional information concerning case history, presenting problems, treatment plans, prognosis, and other case information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health care claims made by or on behalf of the above named patient. This consent shall remain in effect until all claims have been fully processed and all review procedures completed.

_____ _____

Signature of adult patient or parent/legal guardian of patient less than 18 years of age

Date