

**Lori Zoucha, LMHP,CPC, NCC      Fee and Insurance Information Agreement**

Client: \_\_\_\_\_ Acct# \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Wk/Cel Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Clients with insurance**

When insurance coverage is available, clients are charged full fee and the insurance must be used to cover the cost of services. If a client chooses not to utilize this coverage, he/she is responsible for the full fee related to the service.

Most health insurance policies have established deductibles and co-payment that are the client's responsibility. **Lori Zoucha, LMHP, CPC, NCC requires a minimum of at least \$75.00 per therapy session at the time of services to be applied to the cost of services.** Unless the client can provide documentation that his/her responsibility will be less than this amount, the client is responsible for all additional "patient responsible" costs of care as determined by insurance.

**Insurance information - Primary Coverage - attach a copy of the front and back of insurance card to this form**

Name of insured person: \_\_\_\_\_

Insurance Company, plan or program name: \_\_\_\_\_

Insured person's SS#, ID or Medicaid number: \_\_\_\_\_

Insurance policy number: \_\_\_\_\_ Group number: \_\_\_\_\_

Insured person's address (if different than client) \_\_\_\_\_

Insured person's birth date: \_\_\_\_\_ Employer: \_\_\_\_\_

**Client Assessed Fee(s): Self-Pay services**

If you do not have health insurance or other third party coverage, your fee will be based on your verified family size and income. Here are the regular fees assessed for my services: CD Evaluation (90 min) \$200; MH Diagnostic Evaluation (90 min) \$200; Individual (60 min) \$150; Individual (45 min) session: \$120; Group sessions: \$50; Family Session: \$150 Hourly rate for outside administrative work, including court appearances related to client sessions: \$75.

I AGREE that my family size is: \_\_\_\_\_. My Annual Income amount is: \_\_\_\_\_

Due to my financial circumstances at this time, I agree to pay Lori Zoucha, LMHP, CPC, NCC \$ \_\_\_\_\_

for \_\_\_\_\_. I understand that sessions not paid may be billed later and/or sent to billing collection services by Lori Zoucha's billing service. Here is a list of my debts which make full payment difficult

**Acknowledgement of financial Responsibility**

I understand the above information regarding my fee and responsibilities for payment. The financial information I have given is a true and accurate statement of my present financial condition. I will provide verification if asked. **I understand I am responsible for paying my session fee at the time of service.**

**Assignment of Insurance Benefits - authorization to Pay and release Information**

I/we hereby authorize Lori Zoucha, LMHP, CPC, NCC to request payment directly for any and all medical care insurance benefits, either under basic insurance or major medical insurance provisions to which I/we may be entitled as a result of services rendered by Lori Zoucha. I also authorize the release of any information necessary for the completion of insurance forms of the determination of payable benefits. A photocopy of this assignment and authorization shall be as valid as the original. **I understand that pre-verification of insurance benefits is not a guarantee of insurance payment.**

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_