



CLIENT NAME: _____

CLIENT'S DATE OF BIRTH: _____

FINANCIAL COVENANT AGREEMENT**The Center for Counseling & Wellness**

____ INSURANCE (Fill out this section if you are using insurance to pay for treatment)

PRIMARY INSURANCE CARRIER:

Name of Insurance:	Policy #
Policy Holder:	Relationship to client:
Home Address:	City, State, Zip:
Policy Holder's Date of Birth:	Phone #

SECONDARY INSURANCE CARRIER:

Name of Insurance:	Policy #
Policy Holder:	Relationship to client:
Home Address:	City, State, Zip:
Policy Holder's Date of Birth:	Phone #

____ PRIVATE OR THIRD-PARTY PAYMENT (Fill out this section if insurance is not applicable)

Sliding Fee Scale:	Third Party Payor:
Agreed Amount: _____	Name: _____
Staff Initials: _____	Address: _____
	Contact Number: _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE. I understand I am personally responsible for payment of all insurance co-pays and deductibles regardless of any insurance payments made to The Center for Counseling & Wellness (The Center). I authorize The Center to release all information necessary to process any insurance claims or third-party payment. **I authorize payment of insurance benefits directly to The Center.** I understand the **Late Cancellation fee of \$50** is not covered by insurance and is accordingly my responsibility (*does not apply to Medicaid clients*). **I understand if I am a self-pay client, I have the right to a good faith estimate of the cost of each visit and the agreed amount above is such an estimate.** I further understand my account needs to remain current to continue in the counseling process.

Client Signature/Parent or Guardian Signature if Minor_____
Date_____
Counselor Signature or Representative_____
Date