alderwood counseling associates

FINANCIAL AGREEMENT

☐ New ☐ Change Effective Date: _____

Client Name: _____ Date of Birth: _____

☐ **SELF-PAY/UNINSURED:** I understand I am fully responsible for all fees incurred.

☐ **INSURANCE:** I understand I am responsible for any co-pays and deductibles as defined by my insurance policy I understand I am responsible for obtaining pre-authorization for services and that failure to do so may result in the full fee being charged to me.

PRIMARY INSURANCE COVERAGE

Insurance Company: _____
Insurance Company Phone: _____
Subscriber Name: _____
Subscriber Address (if different than client):
_____
Relationship to Client: _____
Subscriber DOB: _____
Insurance ID#: _____
Subscriber's Employer: _____
Plan or Group: _____

SECONDARY INSURANCE COVERAGE

Insurance Company: _____
Insurance Company Phone: _____
Subscriber Name: _____
Subscriber Address (if different than client):
_____
Relationship to Client: _____
Subscriber DOB: _____
Insurance ID#: _____
Subscriber's Employer: _____
Plan or Group: _____

NO SHOW FEE/LATE CANCELLATION POLICY: I understand that I am agreeing to pay for clinician time and that I will be charged a No Show Fee for missed or canceled appointments unless 24 hours is given.

Fee due each session $ _____ No Show fee $ 120.00 Client Initials: _____

- I authorize release of medical information necessary to process my claim.
- I agree to the assignment of all insurance payments to Alderwood Counseling Associates, PLLC, 19031 33rd Ave. W. Ste. 303, Lynnwood, WA 98036. I authorize my insurance carrier to pay benefits directly to Alderwood Counseling Associated, PLLC. I agree to forward any insurance payment I might receive directly to Alderwood Counseling Associates, PLLC. **Insurance does not guarantee benefits. I am responsible for fees not covered by insurance.**
- It is my responsibility to inform my therapist of any changes in my financial status.
- I understand that my portion of the fee is due at the time of service and agree to pay promptly all fees for which I am responsible; failure to do so may result in termination of services.
- A $25 fee will be charged for returned checks.
- **I understand that I will be charged a NO SHOW FEE for missed or canceled appointments unless 24 hours notice is given.**

I have read and agree to the above conditions. **Unpaid fees are subject to collection.**

_____ _____
Client or Responsible Party Signature Date

_____ _____
Parent/Legal Guardian Signature Date