Responsibility for Account
Self-Pay Contract

Client Name: _____ **DOB**:_____

1. I am entering into this self-pay contract because I do not have insurance coverage; or
2. I do not have coverage for behavioral health services under my insurance plan; or
3. I have insurance but choose not to use it. I understand that in doing so I waive my right to be reimbursed by Cyndie Ford Purdy, LMHC for services already received should I change my mind and wish to use my insurance benefits at a later time; or
4. If I have Medicare coverage, I understand that Cyndie Ford Purdy, LMHC is not a network provider and that I will be considered a self-pay client. I understand that I will be responsible for the charges incurred at this office and I agree to pay those fees at the time of service. I understand that it will be my responsibility to file with my secondary insurance carrier. Cyndie Ford Purdy, LMHC will accept the rate schedule of my secondary insurance carrier if she is a participating member of that network and they reimburse me for the services rendered.
5. I understand and agree that I will pay for all charges at the billed rate for the services provided and that payment is due at the time services are rendered unless other arrangements have been made in advance.
6. I understand that Cyndie Ford Purdy, LMHC will charge a late fee on unpaid balances beginning 60 days after the date of service and I accept responsibility to pay these additional charges.
7. I understand that psychological testing fees involve an additional charge and are not included in the charge for the therapy sessions. I agree to pay for these additional charges at the time of service.
8. I understand that appointments must be cancelled at least 24 hours (one business day) prior to the scheduled appointment time to avoid a same day or no show cancellation charge.
9. I understand that in the event Cyndie Ford Purdy, LMHC has been unable to collect payment from me for services received, my account may be turned over to a collection agency.
10. I understand there is a $20 charge for returned checks.

I understand that I am ultimately responsible for all services provided by Cyndie Ford Purdy, LMHC. By signing this form, I accept my financial responsibility and agree to the terms of this contract. If I wish to utilize insurance benefits at a later time, I will inform the office manager for Cyndie Ford Purdy, LMHC so they may contact my insurance carrier to obtain authorization and benefit information. I understand that I cannot obtain reimbursement from Cyndie Ford Purdy, LMHC for services rendered prior to using my insurance benefits.

_____ _____

Client Signature (If a minor, Parent/Guardian Signature) Date

_____ _____

Representative Signature Date Date

☐ Copy given to client ☐ Copy refused by client 03.18.13