Allison L. Sharpe LCMHC, PLLC
COUNSELING & PSYCHOTHERAPY

154 Broad Street # 1527 | Nashua, NH 03063
Phone: 603-236-7774

Statement of Financial Responsibility

You are expected to pay all deductibles, co-pays, and/or percentages at the time of the service. As a courtesy to my clients, I will submit your claims directly to your primary insurance carrier. In the event that your coverage is not valid or your insurance company does not pay for services provided to you, all charges incurred will be your responsibility. If you are using Employee Assistance Plan (EAP) services, you are not financially responsible for these sessions. In the event that you later continue in treatment beyond the limits of your EAP benefit, then you will be financially responsible for those sessions. Your signature below indicates your acceptance of financial responsibility for any charges denied by your insurance carrier, allows us to contact your insurance carrier to verify your benefits and to bill for services, and authorizes payment of medical benefits directly to Allison L. Sharpe, LCMHC, PLLC for services rendered to you. This signature is irrevocable.

I authorize Allison L. Sharpe LCMHC, PLLC to bill any outstanding patient balance each month to the credit card indicated below.

Name as it appears on card:

Card Type: Visa, Mastercard, American Express, Discover

CC# ----------

Expiration Date ----------

Security Code ----------

Address listed with Credit Card, including Zip Code

My signature below indicates that I have read and understand this document and agree to abide by its terms.

Signature: _____ Date: _____