***Great Life Counseling Center***
14673 Midway Rd., Ste. 213
Addison, TX 75001
Kevin C. Lambert, Psy.D., MBA/469-665-9445
GREATLIFECONSULTS.COM

# DEMOGRAPHIC/FINANCIAL RESPONSBILITY FORM

Name/Partner A: _____ DOB: _____/_____/_____ Age: _____

Home Phone: _____ Cell: _____ E-mail:_____

**I authorize text messages to my cell phone and messages to the contact numbers & email provided** YES NO

Residential Address: _____ City: _____ Zip: _____

Employer: _____ Position/Type of Work: _____

Name/Partner B: _____ DOB: _____/_____/_____ Age: _____

Home Phone: _____ Cell: _____ E-mail:_____

**I authorize text messages to my cell phone and messages to the contact numbers & email provided** YES NO

Residential Address: _____ City: _____ Zip: _____

Employer: _____ Position/Type of Work: _____

Referred by: □ Insurance Company □ Internet Search □ Physician □ Friend □ Other: ___

**Insurance information**

Name of Insured (Policy holder):_____ Date of Birth of Insured: _____/_____/_____

Insurance Carrier: _____ Insurance Phone#: _____ Co-pay $_____

Deductible: _____ Deductible Met: _____ Pays at: _____

Policy/ ID#: _____ Group#: _____ Employer: _____

## FINANCIAL RESPONSIBILITY

- Great Life Counseling Center clinicians are currently out-of-network providers for all insurance companies, except Blue Cross Blue Shield PPO.
- If you would like to pay through BCBS, please contact your representative to verify coverage details & inform your psychologist prior to your initial appointment. Great Life Counseling Center will bill your insurance company directly for services provided minus your copayment. Great Life Counseling Center may be required to release the required information about your care to your insurance provider including, but is not limited to, diagnosis codes, dates of service, treatment plans, and treatment progress.
- Private payment of services, copays, and administration fees are due at the time of each appointment. Walkout statements can be downloaded through your profile with our electronic health records system-TherapyAppointment.com.
- If your insurance company should deny payment or reimbursement, you remain ultimately responsible for any outstanding financial debt associated with services provided, including no show/late cancellation fees. Great Life Counseling Center reserves the right to charge a client's credit card, email or mail client an invoice, and/or utilize a collection agency in efforts to address outstanding balances.

**Please Acknowledge the Above Statements with Initials _____ _____**

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**FEES & PAYMENT:**

- Payment is due at the time services are rendered in the form of **cash, check, or charge**. All checks should be made out to **Great Life Counseling Center.** MasterCard, Visa, American Express, & Discover are accepted. Detailed receipts can be downloaded from your profile on TherapyAppointment.com.
- Clients will be given the option to add no show or late cancellation charges to the cost of the next session, as long as the next session is scheduled to occur within 10 days of the cancellation. Clients are also welcome to mail a check by the 10 day deadline. Please note: no show/late cancellation fees are not usually reimbursed by insurance companies.

**SUMMARY OF PRIVATE PAY FEES**

***Direct Contact Fees (may be covered by insurance):***

**Therapy Sessions**…….**All sessions (per 55 minutes) = $200**
**-- Weekend sessions = additional $25 per hour**
**-- Additional time pro-rated by 15 minute increments**

**Phone & E-Consultation fees ……15 min. or less - FREE; 15+ min. - $200/hour (pro-rated)**

***Indirect contact/Administration fees (not covered by insurance)***

**Other services** (i.e. write letters, fill out forms, report writing)……**$100/hour (pro-rated)**
**Legal** (i.e., attorney calls, reports, testimony preparation & court appearances)……**$250/hour (pro-rated)**
**Preparation of Record Summary Letters.**……**$100.00/hour (pro-rated)**
**Returned/Invalid Check Fee**……**$50.00**
**Late Cancellation Fees** (less than 24 hours of notice)……**50% of session fee**
**No show Fees** (notice not provided prior to scheduled appointment time)……**100% of session fee**

- If Dr. Lambert has authorized a session rate modification/discount/coupon, please note on line below.

_____

- Clients are responsible for making sure Great Life Counseling Center has updated contact & billing information. Clients are financially responsible for costs incurred when an insurance claim is denied due to changes in, lapses or exhaustion of benefits or termination of coverage for any reason. Great Life Counseling Center reserves the right to charge a client's credit card, email or mail client an invoice, and/or utilize a collection agency in efforts to address outstanding balances.

**With my signature below, I acknowledge the statements above and accept financial responsibility for services rendered. I authorize Great Life Counseling Center to bill me directly for services provided, not covered by insurance, or any administration fees not covered by insurance.**

**Client/Partner A Signature: _____ Date: _____**

**Client/Partner B Signature: _____ Date: _____**

*A copy of this completed & signed document will be provided at your request.*

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# Credit Card Authorization Form

****It is the policy of this office to keep a debit/credit card on file. You may pay by cash or check, but a card must still be kept on file.****
**This policy exists both for your convenience as well as a way to insure that outstanding balances are paid in a timely manner. You will be notified via phone/voicemail, text, and/or email prior to any charges being applied to your card.**

**With my signature, I authorize Great Life Counseling Center to charge my credit/debit card & imitate my signature for the e-sign authorization for the following outstanding charges:**

- **All visits for which payment was not made at time of visit (this includes fees for service, deductibles, and co-pays).**
- **50% of the session fee for each late cancellation (less than 24 hours of notice)**
- **100% of the session fee for each no show**

_____ _____
**Client/Card Holder Signature** **Date**

**Name** _____
*Print Last* *First* *Middle Initial*

**Name on Card (if different)**

## Type of Card: □ Visa □ MasterCard □ Discover □ American Express

Credit Card Number _____ - _____ - _____ - _____ CVV Number _____ 3-digit number on **back of** card or 4-digit number on **front** of AE card

Expiration Date _____

Card Holder's Billing Address for Credit Card Statements:

_____
Street Address Apt./Ste./Room #

_____
*City* *State* *Zip*

**Card Holder Signature** _____, Date ____ /_____ /____

***Email address and/or phone number for receipts*****_____**

*A copy of this completed & signed document will be provided at your request.*