# CLIENT FINANCIAL AGREEMENT

Payment of session fees, insurance co-payment, coinsurance and deductible, or other charges are due at the time of service unless prior arrangements have been made with Katharine Martin/KM COUNSELING. Verification of insurance coverage and referrals is the responsibility of the client.

There will be a $ 35.00 charge for all checks returned for any reason.

There may be a charge for telephone consultations over 10 minutes. Insurance plans will not cover these charges.

A statement will be sent on a monthly basis. You are financially responsible for all charges. This may include a balance remaining after payment of insurance benefits, charges for non-covered services or missed appointments, and any billing charges, collection agency fees of up to 60% of the delinquent balance, and legal fees related to payment of your account in full. All delinquent accounts will accrue added billing charge of 1.5% on a monthly basis. If payments are not made as agreed, your account may be turned over to a collection agency after 90 days delinquency.

**Mental Health Evaluation/Assessments/Consultations:** Reports for probation, court, disability, FMLA, and letters to physicians, teachers, schools and completion of paperwork are pro-rated for the amount of time taken to prepare the report. All reports and court testimony must be paid in advance of receipt of report or court testimony.

**____** (*initial*) **If you need to reschedule or cancel an appointment, I require a 24-hour notice.** If I have notice, I can offer the time to another client. Failure to provide notice will result in a full charge for the missed appointment. This charge may be waived in the case of illness, unforeseen sudden circumstance, or emergency.

**INSURANCE INFORMATION**

Insured Name and Address of primary person:

_____

_____

Employer:

_____

Insurance company:

_____

*Please provide a copy of your insurance card and photo ID.*

*If different than client, Insured Relationship to Client*:

_____

Insured DOB:_____

Insured phone#:(____)_____

Insurance Policy number:_____

Insurance Group number: _____

By signing here I agree to the policies set forth in the Financial Agreement, **and** I authorize KM COUNSELING/KATHARINE MARTIN to use or disclose my personal health information to my health insurance carrier or other covered entity for the purpose of continued care and payment. I understand I am financially responsible for charges not covered by this authorization.

_____ _____ _____

Print Client Name Client/Guarantor Signature

_____ _____ _____

Print Parent/Guarantor Name (if child or other) Guarantor Relationship to Client Date

*Edited 01/2022*