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 Sonja Glad. Verification of insurance coverage and referrals is the responsibility of the client.

There will be a $ 25.00 charge for all checks returned for any reason.

There may be a charge for telephone consultations over 5 minutes. Insurance plans will not cover these charges.

You are financially responsible for all charges. This includes the 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. We add a billing charge of 1.5% accrued on a monthly basis to all delinquent accounts. If payments are not made as agreed, your account may be turned over to a collection agency after 90 days without a payment.

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.

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 or unforeseen emergency.

Insuralnce Information

Insured Name and Address (If different than client):
_____
_____
_____

Insurance phone # _____

Insured Relationship to Patient:_____
Insured SS#:_____
Insured Date of Birth:_____
Policy and Group number:_____

Please allow us to make a copy of your insurance card and photo ID. If we forget to ask you, please let us know.

By signing here I agree to the policies set forth in the Financial Agreement, and I authorize Sonja Glad, or her representative, to submit claims for services to my insurance company, and authorize my insurance company to make payment for these services directly to my provider.

_____	_____	_____
Print Patient/Guarantor Name	Patient/Guarantor Signature	Social Security #

_____	_____	_____
Print Patient Name (if child or other)	Guarantor Relationship to Patient	Date