FINANCIAL RESPONSIBILITY FORM ** To be completed by person assuming financial responsibility for services provided (Responsible party must be 18 years of age or older)

Your insurance coverage is a contract between you and your insurance agency. It is your responsibility to know your insurance benefits, deductible, coinsurance and copay. We have listed the insurances agencies we are in network with on our website, but this does not guarantee payment from your insurance company as your individual plan determines services covered. It is your responsibility to contact your insurance company to find out if we are in-network and if the services you seek are covered, including any exclusions in your insurance policy, and any pre-authorization required.

It is your responsibility for payment of copays, coinsurance, deductibles and all other treatment not covered by your insurance plan. If an insurance claim is denied, you will be responsible for payment. The credit card kept on file will be charged for ALL services not covered by your insurance carrier, including but not limited to , copays, deductibles, coinsurance, no show fee, late cancelation fee (less than 24 hours from time of appointment). ALL payments are due at the time of service.

Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered.

It is your responsibility to provide CURRENT and ACCURATE insurance information, including any changes in insurance provider, additional insurance companies, updates or changes in coverage that may occur throughout treatment. Should you fail to provide this information, you will be financially responsible.

I agree to inform Compass Counseling Services LLC , If I have more than one insurance

I agree to inform Compass Counseling Services LLC if any changes occur with my insurance in any way.

I understand and agree I am financially responsible for services including: copay, coinsurance, deductible, denied insurance claims, no show fees, and/or late cancelation fees.

I understand and agree the Credit Card on file will be charged for ANY and ALL expenses no covered by insurance.

* **By checking this box, I am agreeing that I have read the financial policies contained above, and my signature below serves as**

acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.