FINANCIAL AGREEMENT

Client's Name: _____

Financially responsible Party_____

Relationship to Client (circle one): Self Spouse Parent Other: _____

FINANCIAL RESPONSIBILITY: I, the undersigned, hereby agree to assume full responsibility for any and all current charges for services rendered by Michael Hollingsworth, LCPC, LLC to the above named client. Fee is $200 per session, $240 for the initial intake assessment and $25 for any requested letters, unless otherwise arranged 1) through provider contract with your insurance company; 2) or other payment provisions are made by provider.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and direct my insurance company or companies to make direct payment to Michael Hollingsworth, LCPC, LLC under any and all applicable coverage, including major medical, for covered charges resulting from services rendered by Michael Hollingsworth, LCPC, LLC to the client named above.

PAYMENT OF BALANCE DUE: I will pay the full amount of charges for all services rendered which are not paid directly by my insurance company or companies, or credited in accordance with the requirements of my health care plan.

CREDIT BALANCES: Any credit balance on my account will be used to offset charges for future services for the above named client or applied to a current balance for any other clients of Michael Hollingsworth, LCPC, LLC for whom I am the responsible party. Any credit balance remaining at the end of treatment will be refunded to me.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: In compliance with HIPPAA, authorization is hereby given to release to my health care plan or insurance company or companies, or to any of its contracted/designated agent, any and all medical information essential to certify the medical necessity and appropriateness of services rendered, and/or to process any claim for reimbursement of charges incurred for services rendered or for the purpose of determining continued eligibility and/or audit for quality of care.

DELAY OF PAYMENT: If full payment is not received within 90 days, the undersigned shall be in default. Upon default:

1. Interest will be added to the outstanding balance at the rate of eighteen percent (18%) per annum.
    a. (1.5% per month) on the total outstanding balance (charges plus accrued interest) each month.
2. The total outstanding balance may be declared immediately due and payable in full without further notification.
3. Accounts in default may be referred to a collection agency, along with the defaulter's name, address, and phone number, balance due, and any other information necessary to contact the defaulter.
4. We have the right to exercise any or all of these legal rights and remedies at any time before the total outstanding balance of a defaulted account is paid in full.

I, THE UNDERSIGNED HEREBY CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FINANCIAL AGREEMENT REGARDING ASSIGNMENT, AUTHORIZATION, AND DELAY OF PAYMENT. I UNDERSTAND THAT, SHOULD MY ACCOUNT BE DEFAULT, CERTAIN ITEMS OF MY PROTECTED HEALTH INFORMATION (PHI) MAY BE DISCLOSED FOR THE PURPOSES OF COLLECTION. I HEREBY AUTHORIZE AND CONSENT TO THE TERMS INDICATED.

Printed Client Name: _____

Client/Parent/Guardian Signature: _____ Date: _____

◆ *Cash, Check and Credit/Debit Cards Accepted* ◆