DOWNTOWN Counseling CENTER
155 S. Hanover Street • Carlisle, PA 17013 • P: 717-386-5971 • F: 717-386-5635
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AGREEMENT FOR PAYMENT AND AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I understand that any co-payment, co-insurance, or out-of-pocket payment is due at the time services are rendered/provided. _____(Initial here)

I understand that I am expected to give 24 hour advance notice if I cancel or change my appointment at Downtown Counseling Center (DCC). If I do not give 24 hour advance notice and miss my appointment or cancel my appointment less than 24 hours beforehand I may be charged $60. In addition, if I miss or cancel three consecutive appointments or miss or cancel four appointments in any eight week period the clinic may elect to terminate our relationship with you. My insurance company will not reimburse me for the cost of a missed appointment._____(Initial here)

By signing below, I agree to contact my insurance carrier to verify and understand my own benefits and coverage. I understand that DCC can give me an estimate of my insurance costs, but that the final decision is up to the insurance company. If for some reason, my insurance company refuses to pay, I am responsible for payment. I authorize DCC to apply for benefits on my behalf for covered services rendered. I request payment from my insurance to be made directly to DCC. I certify that the information I have reported about my insurance(s) is (are) correct. I also understand that DCC may release necessary information for this or any related claim to my insurance company. I permit a copy of this authorization to be used in place of the original. _____ (Initial here)

If using insurance, I give permission for DCC to release treatment records to my insurance company if/when my insurance company requests to review my records for audits, data and coding accuracy._____ (Initial here)

I understand that reimbursement from my insurance company and my co-payments/co-insurance payments cover the cost of therapy sessions, routine case notes, and brief phone calls. I also understand that other costs are **not** covered by insurance (including, but not limited to telephone consultations 10 minutes or longer, responding to emails, written reports, and preparation for and appearances related to court cases). If such costs are incurred on my behalf I agree to pay: **$165/hour for written reports, extended telephone discussions, and similar activities; $165/hour for activities related to legal claims.** _____ (Initial here)

I understand it is my responsibility to PROMPTLY inform DCC of any insurance changes. If DCC is unable to collect from my insurance due to my delay in reporting changes, I will be responsible for making required payments. _____ (Initial here)

I agree to provide DCC with a non-expired, current credit or debit card information to be kept on file. This information will only be used to pay required copays (if needed) or to pay outstanding balances due. _____(Initial here)

For separated, divorced, or multiple payers, I agree that only one credit or debit card will be kept on file to pay required copays (if needed) or outstanding balances._____ (Initial here).

_____ _____

Insured/Authorized Person Date

Downtown Counseling Center Provider Date