FAMILY MATTERS
COUNSELING CENTER

FINANCIAL OBLIGATIONS

I understand that as a courtesy to me, Family Matters Counseling Center, LLC will file to my insurance provider.

I understand that I am responsible for payment of services rendered and also for paying any co-payment or deductible that my insurance does not cover.

I hereby authorize payment directly to Family Matters Counseling Center for the group benefits otherwise payable to me.

I hereby authorize the release of any information, including the diagnosis and records of treatment rendered, to my insurance company.

I understand that I am personally responsible for all costs of mental health treatment at time of service; this includes all co-pays and fees.

I understand it is my responsibility to obtain prior authorization for treatment from my insurance provider.

I understand that my insurance provider is not responsible for any No-Show/Late Cancellation charges and I will be directly responsible for these charges.

I hereby acknowledge that I have received a copy of this Financial Obligation

Client Name (Please print)_____

Client Signature _____

Date Signed _____