FINANCIAL AGREEMENT

(Please print all but your signature. Thank you!!)

****Complete Section (A) if using "In-Network" insurance benefits. For all others, complete Section (B).**

A. In-Network Insurance Authorization:

Kim Christiansen, LPC, CADC III and the billing service contracted with Kim Christiansen, LPC, CADC III have my permission to bill my insurance company(s) and to provide necessary information for the purposes of obtaining authorization for services, benefit information, and payment. I agree that payments or copays for service are due at the time of the service and the responsibility for payment is mine. Denial of payment by an insurance carrier or other third party does not waive my responsibility to pay. I understand that no show or late cancelled sessions (less than 24 hours notice) will be charged to me at full fee and cannot be charged to my insurance company. I also understand that there is a returned check processing fee of $25.00.

____

Signature   Date

B. Out-of-Network Insurance Benefits or Out-of-Pocket Payment Agreement:

I, ____, am choosing to make out-of-pocket payments for the clinical services I receive with Kim Christiansen, LPC, CADC III. I am doing this for the following reason(s):

- ☐ I do not presently have insurance that covers mental health benefits.
- ☐ I have mental health benefits with ____ (Insurance Company), however:
  - ☐ I have exhausted my current outpatient mental health benefits.
  - ☐ I am choosing not to use my insurance benefits at this time.
  - ☐ I wish to be treated by Kim Christiansen, LPC, CADC III, who is not a paneled member of my insurance network. However, I authorize Kim Christiansen, LPC, CADC III or any billing service she works with to submit claims to my insurance if I have out-of-network benefits available. If claims to out-of-network benefits are submitted, I understand that some plans will direct me to pay the entire billed amounts in full, and I will be reimbursed directly by my insurance company for approved claims.
  - ☐ My concerns are not covered by my insurance benefits and are not deemed medically necessary by my insurer.

Fees for Service: $200 Assessment; $160 Individual Therapy; $180 Family/Couple Therapy; Other: ___________________

C. Agreement to Begin Treatment:

This agreement pertains to services beginning ____________________ (date) and will remain in effect until such time as a new written agreement is made, or a valid insurance authorization is obtained and I consent for Kim Christiansen, LPC, CADC III to bill my insurance, or I leave treatment. I agree to make out-of-pocket payments at the time that services are rendered. These payments can be made by cash, check, or debit/credit cards (Visa, MasterCard, Discover, or American Express).

____________________________	________________________________	__________
Client Signature	Printed Name of Client	Date
____________________________	________________________________	__________
If minor, Signature of Legal Guardian	Printed Name	Date