FREEDOM Behavioral Health Services
Patricia S. Bock, LCSW, LCAS, CCS
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PO Box 1418, Clayton, NC 27528
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FreedomBHS@gmail.com

FINANCIAL AGREEMENT

Client Name: ____ DOB:__________________Phone: ______________________

Address: ____ City: ______________________ State: ______ Zip: ___________

Guarantor Name: ____ Phone: ____________________________

Address: ____ City: ______________________ State: ______ Zip: ___________

FOR MEDICAID/NC HEALTH CHOICE CLIENTS ONLY (please initial where appropriate)

_____________ My child has seen another outpatient therapist in this calendar year.

(Therapist name) ______________________ on _________________ date, for approximately ________ number of visits this calendar year.

_____________ My child has not seen another outpatient therapist in this calendar year.

____________ I or my child do not have any other insurance besides Medicaid/NC Health Choice.

____________ I or my child have another insurance policy with ____________________________, policy # ________________________________, group # ______________________________ (card copy provided).

TERMS

1. I, ______________________ certify that the above information is correct and complete.
2. FEES FOR SERVICES: I AM RESPONSIBLE FOR THE FULL COST OF THE SERVICES. I understand that the amount I actually pay may be reduced by the amount paid by insurance. My per session cost will be $____________. I understand that when using insurance, the initial payment agreement is an estimate based on benefits information provided by my insurance company and is subject to change.
3. CHANGES: I agree to notify Freedom Behavioral Health Services (Patricia Bock) of changes in my insurance or county of residence.
4. ASSIGNMENT OF INSURANCE:
   a. I understand that if my insurance/third party listed does not assign benefits to Freedom Behavioral Health Services (Patricia Bock), I will be responsible for filing my own insurance. In this case, I am responsible for the full cost of services.
   b. I understand that if my insurance company requires that a doctor supervise services that I receive, this may prevent payment for certain services.
   c. I understand that if Freedom Behavioral Health Services (Patricia Bock) is not a listed provider of services for my insurance/third party, a claim may not be paid.
   d. If my insurance/third party requires pre-certification, I am responsible for obtaining authorization prior to or at the time of services. Failure to do so will result in benefits being reduced or denied.
5. AUTHORIZATIONS:
   a. I authorize use of this form on all my insurance submissions. I authorize release of any information from my medical record to my insurance company and authorize Freedom Behavioral Health Services (Patricia Bock) to act as my agent to obtain payment from my insurance company.

b. I authorize payment directly to Freedom Behavioral Health Services (Patricia Bock) and hereby assign right to reimbursement for services rendered by Freedom Behavioral Health Services staff.
c. I permit a copy of this authorization to be used in place of the original.

6. APPOINTMENTS: I agree to notify my service provider at least 24 hours in advance if I cannot make a scheduled appointment. If I fail to do so, a charge may be applied.
7. REFUSAL TO PAY: I understand that if I am able to pay for services either in full or through payments, but refuse to do so, my account may be turned over to a collection agency and/or the courts.
8. I understand that fees for services and/or fee policies are subject to change.

By signing this document, I fully accept and understand that the above terms of payment are my responsibility.

____ ____________________
Client/Parent/Legal Guardian /Policy Primary Date

____ ____________________
Guarantor Date

____ ____________________
Policy Primary Date

INSURANCE CONTRACT

Freedom Behavioral Health Services is happy to verify your insurance eligibility. We need a copy of your original, current insurance card prior to intake session. We will verify your eligibility each time you receive a new card. Please always bring the original copy of your new insurance card to each session.

Ultimately, you are responsible for fees if your insurance refuses to pay for services rendered. Our services start at $125.00. Under special circumstances, clients may apply for a sliding scale fee based upon their ability to pay. Sliding fee payments for service are considered on a case by case basis. If you applied for a new card or your insurance eligibility expires, you will be responsible for the full fee for the service you received.

We cannot file insurance claims for late cancellations and for no-shows. If you need to cancel or reschedule your appointment, please contact FBHS 24 business hours' prior to your scheduled appointment or you will be assessed the cancellation amount of $50.00. After three (3) cancellations and/or no-shows within a 30-day period, you will be removed from the current client list and your name placed on a waiting list for 30 days prior to scheduling another appointment.

If you are considered a no-show for the intake session, FBHS will not be able to reschedule another appointment for you until the full fee is paid for the missed appointment.

Also, please be aware that if FBHS is required to by subpoena or requested by you to take part in any legal proceeding, the fees for legal services are $250.00 per hour with a two hour minimum. There are no discounts available for court related services.

____ ____________________
Client/Parent/Guardian Signature Date

____ ____________________
Administrative Signature Date