Life Skills Institute & Clinic

FINANCIAL ARRANGEMENTS

NAME____DATE_______________

ADDRESS____

HOME PHONE__________________CELL ______________WORK______________________

BASIC FEES

Individual Therapy	$175 per 45 min. (pro-rated after that) $200. For 60 min.
Intake Session	$250.00 per hour
Group Therapy	$100.00 per session
Psychological Testing	(varies depending on the test)
Report	$200.00 per hour

PLEASE NOTE THERE IS A 48 HOUR CANCELLATION POLICY.

YOU WILL BE BILLED FOR YOUR APPOINTMENT IF MISSED.

INSURANCE COMPANY____

ADDRESS____

INUSRED PERSON_____________________RELATIONSHIP____________Insured DOB_______

Insured place of work______________________________ Policy Holder DOB ______________

GROUP#___________________________POLICY#__________________________________

MEDICAL ASSISTANCE#______________________ SOCIAL SECURITY#______________________

DEDUCTIBLE________________CO-PAYMENT___________MAXIMUM BENEFIT______________

PRIOR AUTHORIZATION___________________ 2nd INSURANCE COMPANY __________________

ADDRESS____

INUSRED PERSON___________________________________RELATIONSHIP__________________

GROUP#_________________________POLICY#____

DEDUCTIBLE________________CO-PAYMENT___________MAXIMUM BENEFIT________________

I authorize the release of any medical or other information necessary to process this claim. This authorization also includes the submission of electronic claims and/or paper claims. I also request payment of medical benefits from either a government or non-government source to Margaret Green EDD., L.P. I authorize Margaret Green EDD., L.P. to initiate a complaint to the Insurance Commissioner on my behalf. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered, and I understand that I will be charged 1.5% monthly or (18% annual percentage rate) with a minimum monthly fee of $1.00 on any non-contract insurance balances over 30 days. I further understand that I will be legally responsible for all collection costs involved with the collection of this account including all court costs, reasonable attorney fees and all other expenses incurred with collection if I default on this agreement. While Margaret Green EDD., L.P. will aide in the processing of my non-contract insurance claim, I understand that if my insurance does not pay within 60 days, my account will be determined as self-pay and due in full by myself. I certify this information is true and correct to the best of my knowledge.

SIGNED____DATE______________