Sharon M Gaffney
Counseling

Sharon M Gaffney Counseling
1300 Capitol Drive, Suite 103
Oconomowoc, WI 53066

PAYMENT AGREEMENT

Name of Client:_____ DOB: _____

I, _____ understand and agree to the following payment agreement with Sharon M Gaffney Counseling, LLC. My insurance company was contacted and the following was quoted as my benefits:

Name of Insurance:_____

PRIMARY
In-Network Benefits:_____
Deductible:_____ Copay:_____
Session Limits:_____ Preauthorization #:_____

Out of Network Benefits:_____
Deductible:_____ Copay:_____
Session Limits:_____ Preauthorization #:_____

SECONDARY
In-Network Benefits:_____
Deductible:_____ Copay:_____
Session Limits:_____ Preauthorization #:_____

- I understand that insurance companies sometimes fail to reimburse for unexpected reasons. After 60 days from clean claim submission, if there is not a payment by insurance, I assume responsibility for what is owed and it will become my responsibility to be reimbursed by my insurance company. _____
- I understand that it is my financial responsibility to inform Sharon M Gaffney Counseling LLC, of any changes in my demographics of insurance information.
- I understand that I am responsible for payment and appointments that are not cancelled within 24 hours.
- I understand that my insurance company will not reimburse all services provided by my treatment provider and that my signature on this form confirms my consent to this. I understand that I have the right to revoke my consent in writing if desired.

- I understand that I can request an explanation of my rights as they pertain to private health information.
- Co-pays, co-insurance, deductible, out-of-pocket services and/or non-covered services are due each session.
- I understand if my ex-spouse holds an insurance policy on my child; consent to bill this insurance must be obtained by my office for billing proper to treatment.
- If you are a legal guardian that can make medical decisions independently and you do not wish to seek consent from the child's other parent, be advised that you assume full responsibility for the bill. Disputes over payments are not my responsibility.

_____

Client Name (Printed)

_____

Client Signature (ages 14 and up) Date

_____

Parent/Guardian Signature (if a minor under age 18) Date

_____

Therapist Signature Date

Sharon M Gaffney Counseling

Credit Card Authorization

Client Name:_____ Client DOB:_____

Name on card: _____

Credit Card Number:_____

Expiration Date:_____ CVV:_____

Billing Address:_____

City:_____ State:_____ Zip:_____

___Amex ___ MasterCard

___Visa ___ Discover

By signing this form, I authorize the above-designated therapist at the above-designated location to charge my credit card for services provided as agreed upon during the informed consent process.

Signature of Cardholder: _____

Date: _____

You retain the right to revoke this authorization.
This authorization will remain in effect until written notice is provided.