A Family Works, Counseling PLLC

1760 E Boston St. Suite 102
Gilbert, AZ 85295
480.649.6499

CLIENT FINANCIAL AGREEMENT

AFWC will make every attempt to comply with your insurance company's requests. Since policies and benefits differ among employers and individuals, we are unable to know the specifics of your policy. Your insurance company informs all participants that ultimately it is your responsibility to verify your benefits and coverage prior to receiving any services.

Session duration is determined by your individual insurance policy.

Unless other arrangements have been made in advance, full payment, or the appropriate co-pay or coinsurance is to be **made at the time of the office visit.**

Missed appointments, or appointments not cancelled with at least 24 hours notice, will result in a charge to the credit card on file. Be aware that your insurance will not pay for missed appointments. The benefit of blocking out 45 minutes of the therapist's time specifically for your visit is that you will rarely have any significant wait time – you will be seen immediately (unlike many doctor's offices). However, if you fail to keep your appointment, or fail to cancel more than 24 hours prior to the session, this block of time is no longer available to others and will still be billed to you.

Once the claim has processed and a balance remains on the account, we will email a statement and attempt to contact you at least once. Then, the balance on the account will be processed on the credit/debit card on file. Account balances left unpaid for 90 days or longer will be subject to collection fees of 10% per month. Unpaid balances will be turned over to a collection agency.

I understand that if collection procedures are initiated against me my identifying information (nonmedical) and payment history will be released to the collection agency.
I understand that my insurance will be billed on my behalf by this office, however, I remain legally responsible for all fees due to the therapist. This billing is done solely as a courtesy, not as an assumption of responsibility.
I authorize the release of any medical or other information necessary to process all claims.
I authorize payment of medical/insurance benefits directly to A Family Works, Counseling PLLC.
I authorize a $50 charge to my credit/bank/HSA card if I fail to keep or cancel my appointment according to this agreement.

Cardholder's Name: _____ Credit Card #: _____

Circle One: Mastercard/Visa

Expiration Date: ☐☐/☐☐

Security Code: _____ (3 digit code on back)

I have read and understand the above as witnessed by my signature.

_____	_____	_____
Client Name	Responsible Party Printed	Responsible Party Signature
		_____
Please list all other family members for this card.		Date
_____	_____	_____
_____	_____	_____