FINANCIAL AGREEMENT

This is a Financial Agreement between _____ hereinafter known as "I", "You", "Your" or "My" AND **Constance Avery-Clark, Ph. D., LLC** hereinafter known as the "Corporation", "We" or "Us". As an independent contractor of the Corporation, your clinician has entered into a separate agreement with the Corporation in which your clinician has assigned the collection of his/her fees to the Corporation.

Your financial obligation depends on whether you are using managed health care (such as an HMO or PPO) or whether you are choosing not to use insurance or you have an insurance plan which pays a percentage of the total charge (such as 80/20 split plans).

□ Your therapist has agreed to provide counseling and/or psychotherapy to you at the rate of $_____ per session. (Self pay individuals and 80/20 split or similar indemnity insurance plan).

OR

□ If you are using managed care, your therapist has entered into a contract with your managed care company to provide services at a specific rate which requires you to pay a copay of $_____ per session***. (For individuals using Managed Care such as HMO's and PPO's).

*** The copay amount indicated above is our good faith belief based upon information obtained by us from your insurance company. However, it is possible that after submitting your insurance claim, it is determined by your insurance company that your insurance policy requires a copay of an amount different from that stated above. Please be aware that should your copay be greater than that stated above, you will be responsible for the additional funds due.

Please initial EACH line acknowledging your agreement to and acceptance of the following additional terms of this Agreement.

_____ I understand and agree that I am directly responsible to the Corporation for all bills submitted to me for services rendered by the patient's clinician.

_____ I understand that payment for each session is due prior to obtaining services and agree to pay the above-stated amount due prior to each session.

_____ **24 HOUR LATE CANCELLATION/NO SHOW POLICY:** I understand and agree that I will be charged $50.00 for a missed appt.

If you are using insurance, you must initial these statements as well. If you are not using insurance, you may skip this section.

_____ I understand and agree that although the Corporation will contact my insurance company in order to obtain benefits, the benefits information given to the Corporation may be different than what my insurance company actually pays. (ie., when we call to obtain your insurance policy benefits, we may be told that your copay is only $15; but after submitting your claim, we learn that your copay was actually $25, you will be responsible for the additional $10 dollars that you are required to pay by your insurance company).

_____ Therefore, I agree that I am ultimately responsible for confirming the copay amount per visit from my insurance company prior to services being rendered and should I or the Corporation be misinformed by my insurance company as to the amount of my copay, I will be responsible for any additional funds due to the Corporation.

_____ I understand that if my insurance company requires Pre-Authorization prior to being seen by my clinician, I will make the necessary arrangements to obtain Authorization prior to being seen by my clinician.

_____ I further agree that if I fail to obtain this Pre-Authorization or change insurance companies after obtaining Pre-Authorization without informing the Corporation prior to services being rendered, I will be responsible for the ***full*** contracted rate agreed on between my clinician and my prior insurance company which authorized the services rendered.

_____ I agree to pay any deductible amount, co-insurance, or any other balance not paid by my insurance company.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of Collection. By signing below, you acknowledge your understanding and acceptance of the terms of this agreement.

_____ _____ _____

Name of Responsible Party | Signature of Responsible Party | Date

_____ _____

Social Security Number of Responsible Party | Patient Name