JAMES DREW, MA, LPC, PSYCHOTHERAPIST
FINANCIAL AGREEMENT FOR PSYCHOTHERAPY SERVICES

DEMOGRAPHIC INFORMATION

Full Name: _____ Date of Birth: ____/____/____

Home Address: _____ Home Phone: _____

City: _____ Zip Code: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact—Name: _____ Phone: _____

GUARANTEE OF PAYMENT

James Drew currently accepts MasterCard and Visa credit cards as payment for services. If you intend to use a credit card as payment, complete this authorization form. This information is kept in a locked file and is accessible only for billing purposes. This policy benefits our clients in several ways. First, it expedites you or your family member's departure after the session is complete. Rather than having to wait for your credit card to be run at that time, you are free to leave immediately, knowing your paid receipt will be available to you at the next session or can be mailed to you at your request. Furthermore, it alleviates the hassle of remembering to send payment with your son or daughter, who may visit the office by themselves. In order to maintain a prompt schedule for our clients, we attempt to occupy as little time as possible collecting fees. To this end, we run all credit cards at the end of the business day and receipts are printed for pick up at the next session. Of course, we accept cash and checks; however, most of our clients prefer and have been pleased with this method of payment. We appreciate your cooperation in this matter and encourage you to ask for assistance if you have questions or concerns.

Card Type: **MasterCard** **Visa** Expiration Date: ____/____

Card Number: _____ CVV Code (3-digit code on back): _____

Name of Cardholder (as it appears): _____

Billing Address (if different than above): _____

City: _____ State: _____ Zip Code: _____

SIGNATURE

By signing this form, I agree to pay James Drew, LPC, **$120.00 for the initial counseling session/evaluation** and **$100.00 for all subsequent 50-minute psychotherapy sessions**. I understand that the fee for services will be paid at the conclusion of each session unless prior arrangements have been made. I understand that I must notify James Drew at least **24 hours in advance** if I cannot attend the next scheduled session. Failure to give timely notice may result in my credit card being charged the full fee for service. I understand that any outstanding balance on overdue accounts is subject to a service charge of 1½% per month (18% APR). Furthermore, I understand that after 90 days, if payment has not been made in full or a satisfactory payment schedule has not been arranged, the account may be turned over to a collections agency. I acknowledge that I will be liable for all legal fees and collection fees, in addition to the monies owed. I understand that if I have questions or concerns about any fees or payments, I am encouraged to discuss them openly at any time with James Drew.

If I am utilizing health insurance benefits, I understand that I am authorizing James Drew, LPC, to use and/or disclose my Protected Health Information (PHI) to obtain benefit information, process insurance claims, and receive payment from my insurance company or companies. I understand the information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or Texas privacy law. I understand that James Drew will diligently attempt to obtain accurate information regarding my mental health insurance benefits. I will not hold James Drew liable for insurance non-payment due to misquoted benefits. I acknowledge that I am responsible to read and understand my benefit plan. I am ultimately responsible for all charges my insurance company does not pay, except for contracted network provider discounts that may apply. I understand that billing the insurance company directly is a courtesy provided by this office. I am requesting assignment of benefits to be paid directly to James Drew.

Signature of Client: _____ Date: _____

Signature of Client: _____ Date: _____