Advanced Counseling and Assessment Services

Billing Information

The fee for a full session is due at the beginning of each session.
Payment may be cash, check, or credit card.

Please place an X by the commitment option below.

☐ I am not filing with insurance and will pay for each session **at time of service**.

☐ I will be filing insurance.
Advanced Counseling and Assessment Services will bill my insurance at the fee listed above.
After coverage has been determined, I will pay my co-payment and/or deductible at each session.

If you do not have insurance coverage at this time please go to the bottom of the page, thank you.

Insurance Information

Insured's Name: _____

Social Security #: _____ Date of Birth: _____

Insured's Employer: _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Phone Number/s: _____

Policy Number: _____ Group Number: _____

Filing for secondary insurance is the client's responsibility.

Consent Agreement

I authorize the release of pertinent medical information to my insurance carrier. I am aware health insurance coverage varies. Insurance carriers may use terms such as customary, reasonable, prevailing, etc. to limit their coverage. However, I understand that I am completely responsible for payment of all charges for services rendered by Advanced Counseling and Assessment Services as a result of treatment to myself or my immediate family. I recognize that although I have insurance that may be contracted with Advanced Counseling and Assessment Services, I will be responsible for any deductibles, co-payments, co-insurances, fees not covered by insurance, and/or fees for letters or reports on behalf of disability, compensation claims, school or employer notices, etc.

I am responsible for my account, as my insurance coverage is an agreement between myself and the insurance company. If my insurance company does not pay its portion within a 6-week period of time of the filing date I am responsible for the bill. Any money received from my insurance company after I have paid the bill in full will be promptly refunded to me by Advanced Counseling and Assessment Services.

In the event I fail to pay the balance of the account with Advanced Counseling and Assessment Services, and this account is sent to a collection agency for recovery of payment, I hereby agree that I will pay the fee charged by the collection agency to Advanced Counseling and Assessment Services. In addition, if my account is forwarded to an attorney to undertake legal action to collect the unpaid balances, I hereby agree to pay all the reasonable attorney's fees incurred by Advanced Counseling and Assessment Services in regards to the collection of the unpaid account.

I hereby authorize Advanced Counseling and Assessment Services to release any information required to communicate and process insurance claims in order to secure receiving insurance benefits.

_____ _____

Signature Date