120 Carnegie Place, Suite 202
Fayetteville, GA 30214
404-988-9177

FINANCIAL AGREEMENT AND PROMISE TO PAY ACCOUNT

For in and consideration of services rendered and to be rendered to ________________________ (client name), I will promise to pay Transcendence Child and Family Therapy, LLC (TC&FT). I understand the total charges are due when services are rendered.

I agree to make available any and all insurance information to TC&FT and/or billing personnel. I understand that TC&FT bills from One hundred and twenty-five dollars to one hundred and fifty dollars ($125-$150) for sessions lasting 45-60 minutes, based upon therapist and licensure. I agree to provide insurance claim forms of any insurance company and/or will complete the HCFA 1500 form. I agree to assign any and all benefits to TC&FT and sign in the designated areas on the insurance claim form. I agree to pay the entire deductible amount, as well as any co-payment amount due.

I understand that I am financially responsible for missed appointments, in which I do not give a 24- hour notice and that my credit card will be charged if I do not give the 24 hour notice. The fee for a missed visit (in which less than 24- hour notice is given, including weekends) is $45.00.

In addition, if my insurance company fails to pay for each date of service within four weeks, I will be billed for the date of service. I will be provided with a super bill so you can be reimbursed by my insurance company. In this process, if payment is received after the four week date of service; I will be reimbursed by Transcendence Child and Family Therapy. By signing this agreement I completely understand that it is my responsibility to handle all insurance matters, including getting authorization and untimely payment by my insurance company (more than 4 weeks after date of service). I understand that TC&FT will file each date of service one time and any rejection payment from my insurance company will be taken care of by me.

I understand that I am financially responsible for all charges not covered or denied by my insurance company. I understand that if I should receive payment from the insurance company by mistake, which payment was/should be assigned to TC&FT, I will sign this payment over to TC&FT and TC&FT has the right to seek legal action to receive payment for this agreement, relative to payment fees, TC&FT shall be entitled to reasonable attorney fees and cost of collection.

I further understand that no records (written or verbal) will be released to me or on my behalf if I have an outstanding balance due to TC&FT.

Please provide us with your credit card information. The card will ONLY be billed if less than 24 hour notice is given:

Type of card: ________________ (We accept Visa, MC, AMEX and Discover) Name as it appears on card: ____
Card #: ____ Exp: ________________________ CVV: ______________________

By signing below, I am agreeing to the terms and conditions of this financial contract.

_______________________________ ______________________ Signature Date

_______________________________ ______________________ Witness Date