Everyday Counseling and Coaching Services, LLC
Orly Katz, LCPC, NBCC
1 Research Court. Suite 450
Rockville, MD 20850
(301) 660-6759
therapyorly181@gmail.com

Financial Agreement

I _____, have discussed the following types of financial payment plans and procedures with my therapist, Orly Katz, LCPC

Address: _____

PAYMENT PLAN- Please check A, B or C

_____**Plan A (Private Pay)**

I agree to pay $_____per session. Payment is expected at each session, unless I have made prior arrangements with my therapist.

Date: _____ Signature: _____

Plan B (Employee Assistance Program) _____

Authorization number: _____

Policy Holder: _____

Date of referral: _____Phone # _____

Plan C (Insurance)

Primary Insurance_____

Phone #_____

Policy/ID#_____ Group #_____

Policy Holder_____DOB:_____

Employer Name_____

Social Security Number_____

Please provide your therapist with a copy of your insurance card:

I authorize the release of any medical information necessary to bill insurance claims. I permit a copy of this authorization to be used.

Date: _____Client Signature_____

Our office is pleased to accept your insurance assignment. After verification of coverage we will file your claim forms and assist you in every way we can. However, it must be fully understood that the contract is between YOU and your insurance company and you are fully responsible for any amount not paid by your insurance company.

Our office does not guarantee that your insurance company will pay. We will make every attempt to verify your insurance coverage. However, if for some reason your insurance claim is denied, you are responsible for the full amount of the bill. We will not enter into a dispute with your insurance company over your claim. That is your responsibility and obligation.

I hereby authorize Orly Katz, LCPC to apply for benefits on my behalf for covered services rendered by this office. I request that payments from my insurance be made directly to Orly Katz, LCPC. Should an insurance payment inadvertently be sent to me, I will endorse it and return it to Orly Katz, LCPC immediately.

I understand that I am financially responsible for any unpaid balance by the insurance company within sixty (60) days of the date of service. I certify that the information I have reported with regard to my insurance is accurate. I permit a copy of this authorization to be used in place of the original. I may revoke

Date: _____ Signature: _____

POLICY REGARDING REPORT WRITING AND CONSULTATIONS

If you request your therapist to write reports, you will be billed $100 PER HOUR for a minimum of 2 hours. Please request that your therapist write any needed letters at the beginning of your session, so your session can include information about your request to write your letter.

Finally, if you need your therapist to consult with teachers, principals, other doctors, social workers, attorneys and/or any other professionals, we are happy to provide this service. However, you will be billed for your therapist's time according to their hourly fee and the amount of time needed for the consultation. Again, this does not include brief phone calls. Any report or phone call that takes more than 10 minutes will be billed to you.

Date: _____ Signature: _____

CANCELLATION/RETURNED CHECK POLICY

I understand that appointments cancelled under 24 hours in advance will be billed $100 per session **out of pocket** through my medical billing services. I understand that a $15 service charge will be added to all returned and declined checks.

I understand and agree with all of the above. Please sign your name below and we will accept your assignment.

Date: _____ Signature: _____

I have explained the financial agreement to the above named client(s).

Date: _____ Therapist: _____