Individual, Couple & Family Psychotherapy
Serving Belle Plaine, Burnsville, Cologne, Eden Prairie, Glencoe & Wayzata

925 12th St E, Ste 101; Glencoe, MN 55336
320.864.6139 | 952.361.9700 | fax: 320.864.6130
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Addendum to the Pre-Authorized Healthcare Payment Form

Payment for Service Policy

Please Initial

_____ I understand that my payment is due at the time of service. This includes my co-pay, co-insurance, deductible and any accrued late cancellation/no show fees.

_____ If I use insurance, I understand that I am responsible for the monitoring of my own deductible and that I am fully responsible for the payment at the time of service.

_____ For my initial appointment(s) and until my Explanation of Benefits (EOB) processes, I agree to pay $_____at the time of service to go towards my balance until I know the exact amount that I owe. Once I know the exact amount, I agree to pay this at the time of service.

_____ I have completed and signed the Pre-Authorized Healthcare Payment Form with my credit/debit card information and I authorize the use of this card for copays, co-insurance, deductibles late cancellation/no show fees and any outstanding balances.

If any other arrangement has been made with my therapist, it will be specified in writing below.

_____

Client Signature Date

_____

Therapist Signature Date