FINANCIAL AGREEMENT FOR SERVICES
Please PRINT THIS FORM, fill it out and bring to the first session.

NAME:____

DATE OF BIRTH:_________________

STREET ADDRESS:______________________________________

TOWN:____________ ZIP:_______

PHONE NUMBER
(H)______________________________(C)__________________________________

PRIMARY INSURANCE

INSURANCE COMPANY NAME/PLAN NAME:_______________________________

ID NUMBER:_____________________________

NAME OF PRIMARY HOLDER:_______________________ DATE OF BIRTH:____________

PHONE NUMBER TO VERIFY COVERAGE:____________________________

SECONDARY INSURANCE INSURANCE COMPANY NAME/PLAN

NAME:_____________________________________

ID NUMBER:___________________________________

PHONE NUMBER TO VERIFY COVERAGE:____________________________

ASSIGNMENT AND RELEASE
I AUTHORIZE DEBBIE FASSULA LCSW TO FILE CLAIMS ON MY BEHALF WITH MY INSURANCE COMPANY FOR SERVICES RENDERED. I UNDERSTAND THAT ANY INSURANCE REIMBURSEMENT IS DUE AND PAYABLE TO DEBBIE FASSULA LCSW. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR DEDUCTIBLES AND COPAYMENTS AS STIPULATED BY MY INSURANCE COMPANY. I ALSO UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ALL FEES INCURRED THROUGH THE PROVISION OF SERVICES FROM DEBBIE FASSULA LCSW EVEN IF MY INSURANCE COMPANY DECLINES REIMBURSEMENT FOR THOSE SERVICES.

SIGNED:________________________________ DATE:_______________

BROKEN APPOINTMENTS:

I UNDERSTAND THAT 24 HOURS NOTICE IS REQUIRED TO CANCEL AN APPOINTMENT – OTHER THAN IN THE EVENT OF ILLNESS OR EMERGENCY. BROKEN APPOINTMENTS INCUR A FEE OF $75.

PAYMENT:

PAYMENT IS DUE AT THE TIME OF YOUR APPOINTMENT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. CASH, CHECK, OR VENMO IS ACCEPTED.

RETURNED CHECKS WILL INCUR A $35. SERVICE CHARGE. UNPAID BALANCES IN EXCESS OF 30 DAYS ARE SUBJECT TO BILLING FEES OF 24% PER YEAR (2.00% MONTHLY)

COLLECTION:

I UNDERSTAND THAT UPON COMPLETION OF TREATMENT, ANY UNPAID BALANCE WILL BE PAID BY ME WITHIN 30 DAYS. AFTER A GRACE PERIOD OF 10 DAYS, IF NO PAYMENT HAS BEEN MADE, THE ENTIRE UNPAID BALANCE WILL BE SENT TO A COLLECTION AGENCY. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ADDITIONAL COSTS INCURRED BY THE COLLECTION AGENCY AND/OR DEBBIE FASSULA LCSW IN THE SATISFACTION OF MY DEBT. THIS INCLUDES: ATTORNEY FEES, COURT COSTS, POSTAGE AND HANDLING FEES, CLERICAL FEES, ETC. PRINT

FULL NAME:________________________ SIGNATURE:_______________________________

SOCIAL SECURITY NUMBER:______________________ DATE:_____________________