Financial Agreement

Primary Insurance Information

Insurance Company | Insurance Telephone

Policy ID Number | Group Number

Policyholder Name

Address | City, State, ZIP

Telephone | Social Security Number

Policyholder's Date of Birth | Sex: ☐ M ☐ F

Relationship of patient ☐ Self ☐ Spouse to policyholder ☐ Dependent

☐ Other

Start Date of Coverage _____ Co-pay _____

Consent to Release Information

I **authorize** any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, peer-review organization, insurance or reinsuring company, the Health Care Financing Administration, the Medical Information Bureau, Inc., consumer reporting agency, employer or third party administrator having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents to give the group policyholder, my employer, third-party administrator, my third-party carrier or its legal representative, any and all such information.

I **understand** the information obtained by this authorization will be used to determine eligibility for insurance, and eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal services in connection with the claim or claims submitted by Kelly Harrison C ounseling PLLC or as may be otherwise lawfully required or as I may further authorize. I also **authorize** that payment of medical benefits be made to the physician or organization listed on any claim submitted for any services furnished me by that physician or organization or to an agent contracted by Kelly Harrison as agent for that physician or organization, as directed by the physician or organization.

I agree that these authorizations shall be valid until rescinded in writing or replaced at a later date.

Client Signature (or Legal Guardian if client is a minor) Date

Credit Card Authorization Form

Name: _____ **Date:** _____

I authorize Kelly Harrison Counseling to charge my credit card for the full amount of each counseling session or my copay. I also authorize Kelly Harrison Counseling to charge my credit card for the $75 No-Show Fee if I fail to cancel my appointment within 24 hours.

I understand that it is my responsibility to keep an updated copy of my credit card information on file. If my credit card is declined for any reason, I am responsible for immediate payment of the full balance by cash or check.

Name as it appears on Card: _____

☐ MasterCard ☐ Visa ☐ Discover Card ☐ American Express

Credit Card #: _____ Expiration Date: _____

CCV: _____ Billing Address/Zipcode: _____

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

_____ _____

Client Signature Date