Client's Name (printed): DOB:

Consent for Treatment & Payment of Medical Benefits, Fee Schedule, and Financial Responsibility Form

Thank you for choosing our practice, LifeWorks Counseling Center, LLC. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our consent for treatment, payment, and client financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

Consent for Treatment & Payment of Medical Benefits Initial _____

I give my consent to the practice, LifeWorks Counseling Center, LLC, to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice.

Client Financial Responsibilities Initial _____

- **I (client, financially responsible person, or client's guardian, if a minor) understand that I am ultimately responsible for the payment of my (or the client's) treatment and care.**
- LifeWorks Counseling Center, LLC, will assist me by billing my insurance company. However, I understand that I am required to provide the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that my insurance company may need information directly from me in order to process my claims. Since my insurance benefit is a contract between me and my insurance company, I will comply with their request.
- I understand that I am responsible for the payments of copays, coinsurance, deductibles, and all other procedures or treatments not covered by my insurance plan. **I understand that payment is due at the time of service, payable by cash, check, and most major credit cards.**
- I understand it is my responsibility to know what my insurance benefits are. Lifeworks Counseling Center, LLC, will verify Benefits and Eligibility based on the insurance information I supply. However, copayment, coinsurance, or client responsibility amount may vary during treatment. When the Explanation of Benefits is received by LifeWorks Counseling Center, LLC, any change in the copayment, coinsurance, or client responsibility amount will be reflected in my account. If the amount due is more than I paid at my session, I am responsible for the difference. If the amount due is less than I paid, the difference will be applied to my next session.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but are not limited to):
    - Charge for returned checks
    - Charge for the copying and distribution of client medical records
    - Charge for forms completion
    - Charge for any letter, regardless of length
    - Charge for missed appointments
    - Charge for appointments canceled with less than 24 hours' notice
- If my account falls past due by more than 30 days, I will receive a request from LifeWorks Counseling Center, LLC, asking me to pay the balance in full. Partial payments may only be made with an approved payment arrangement.
  I understand and accept that if I fail to pay my bill or any monies due and owing LifeWorks Counseling Center by the scheduled due date, and fail to make acceptable payment arrangements to bring my account current, LifeWorks Counseling Center, LLC, may refer my delinquent account to a collection agency. **I further understand that I am responsible for paying the collection agency fee which may be based on a percentage (at a maximum of 33.3 percent) of my delinquent account, together with all costs and expenses, including reasonable attorney's fees, necessary for the collection of my delinquent account.** Finally, I understand that my delinquent account may be reported to one or more of the national credit bureaus. My signature at the bottom of this page indicates that I have read, understood, and agreed to the policy of LifeWorks Counseling Center regarding delinquent accounts and associated fees.

Fee Schedule Initial _____

Initial therapy visit (self-pay rate)	$100.00
Second and subsequent visits (self-pay rate)	$85.00*
Online video counseling (in PA only, for individuals 18 years or older). Payable by credit card before consult (self-pay rate). Check with your insurance company to see if this is a covered benefit.	$85.00 per session*
Missed Appointments/Late Cancellations (less than 24 hours' notice)	$85.00
Returned check charge	$30.00 + any bank fees
Disability forms initiated by the client and FMLA	$50.00 - $125.00
Cost to copy/fax records (with signed client consent)	$1.00/page
Standard letter	$60.00
Jury Duty letter	$60.00
Letter/Note/Forms Completion	Starting at $50.00
Back to work note	Starting at $50.00
Legal letter (requested by a lawyer)	$125.00 minimum

*LifeWorks Counseling Center offers a discounted Self-Pay rate of $399.00 for 5 sessions, a savings of $26.00. To receive this self-investment rate, the five sessions must be paid in advance.

Client (or Financially Responsible Party) Authorizations Initial _____

- By my signature below, I hereby authorize the practice, LifeWorks Counseling Center, LLC, to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to the practice, LifeWorks Counseling Center, LLC**. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).**
- By my signature below, I authorize LifeWorks Counseling Center, LLC, to speak with the following person/persons (in addition to myself) regarding any billing issue:
  Name: _____ Phone No. _____
  Name: _____ Phone No. _____

Use of Photography Initial _____

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

By my signature below, I acknowledge that:

- **I have read, understand, and agree to the provisions of this Consent for Treatment & Payment of Medical Benefits and Financial Responsibility Form.**
- **I have read, understood, and agreed to the policy of LifeWorks Counseling Center regarding delinquent accounts and associated fees.**
- **I understand this signed form must be on file no later than the client's second session.**
- **I understand I may request a copy of this signed notice.**

To be completed by Client if age 18 or older (or by Financially Responsible Party):

Print Name: _____ Date of Birth _____

Signature: _____ Today's Date: _____

To be completed by Financially Responsible Party if client is under 18:

Print Name: _____ Relationship: _____

Signature: _____ Date of Birth: _____

Phone No. _____ Today's Date: _____

Copy Declined _____ Copy Received _____

If Client is age 13 or younger, please complete the Additional Consent to treat Minor form.