Abundant Solutions, LLC
Financial Agreement

Abundant Solutions, LLC is committed to your overall wellbeing, including assisting you with making the most of your time and your finances during your counseling experience. The following financial policy addresses your financial obligation in a confidential, equitable, and fair manner.

Client Name _____ **Client Date of birth** __ __/ __ __/ __ __ __ __

INSURANCE INFORMATION

- **I agree to pay my co-payment, coinsurance, and/or deductible at the time of service.**
- **As a courtesy we will verify insurance benefits.** ***Any co-payment, coinsurance, or deductible we charge is based on the benefits provided by the insurance company(s).*** Clients are responsible for any outstanding balance *in the event that the insurance carrier denies benefits, changes co-payment, alters your deductible, retracts a payment, or does not provide benefits as estimated. The client or the Responsible Party is responsible for the balance regardless of the reason the insurance company denies coverage.*
- **Clients must notify our office of any changes to their insurance *no later than 48 hours prior to an appointment*** or client may be responsible for the full standard fee for that appointment.

SELF PAY INFORMATION (*The Self Pay Rate is discounted from the Standard Fee.)*

- **I agree to pay the Self Pay rate of $_____ (cash) per session *at the time of service.***
- **Those paying in cash have received fee reduced by $5.00**
- **If payment is NOT made *at the time of service,* the client will forfeit the discounted fee and will be charged the full Standard Fee for that service date** *(Standard Fees are based on the type of service).*

PAYMENT INFORMATION

- **Full payment is due at the time of service.** *Cash, and credit cards are accepted.*
- **Clients will incur a monthly interest rate of 1.67% (APR of 20%) if their account balance is not paid in full within 30 days of the billing date.** *Client will be responsible for payment of these charges, as well as any collection costs including, but not limited to, attorney fees should collection become necessary.*
- **Clients will be charged $35.00 for a returned or denied payment.**

MISSED APPOINTMENT

- **Clients will be charged $50 for a missed appointment fee *for appointments that are canceled less than 24 hours in advance.* Clients may call the office anytime to cancel an appointment, *messages are date/time stamped***
- **Missed appointment fees are not covered by insurance and are the responsibility of the client.**

ADDITIONAL CHARGES

- **Clients are responsible for additional charges for services agreed upon by the client and therapist** that are incurred during the course of treatment, including diagnostic assessments, reports, and letters.
- **After hours calls, written consultations and telephone consultations of ten minutes or more will be charged at the therapist's discretion and disclosed to the client.**

Abundant Solutions, LLC understands that financial scarcity is a reality for some and addresses this by offering limited assistance. A Financial Hardship Form will be made available by request. Requesters may submit a completed FHF which may lead to services at reduced or no cost. Abundant Solutions, LLC reserves the right to revisit re-instatement of service fees.

A copy of this agreement will be provided upon request for your records.

I accept financial responsibility for the client account and the terms of the payment agreement.

_____	___ ___ ___-___ ___ -___ ___ ___	__ __/__ __/__ __ __ __
Name of **client/Responsible Party** *(if minor)*	**Responsible Party Social Security #**	**Responsible Party** Date of Birth

_____	_____	_____
Signature of **Client/Responsible Party** *(if minor)*	Date	Relationship to Client

Witnessed by: _____ Date _____