Thoughtful Counseling, LLC
5147 South Lakeland Drive, Suite 4
Lakeland, Florida 33813
(863) 701-5127

Payment Policies and Financial Agreement

Thank you for choosing Thoughtful Counseling LLC for your counseling needs. This financial agreement outlines both the client's and insurance responsibilities for services rendered. Please read this agreement carefully, ask any questions you may have, and sign in the space provided.

I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I acknowledge that I will be required to pay a $100 fee for any missed appointment, no-show appointment, or cancellation made less than 24 hours prior to the scheduled appointment.

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Parent/Guardian Signature	Printed Name	Date

Insurance

Your insurance coverage is a contract between you and the insurance company. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. It is also your responsibility to know your insurance benefits including referrals, pre-certifications and required authorizations. We will submit your claims to your primary and insurance companies however we do expect payment for all services within 60 days. It may become necessary for you to pay your account in full if your insurance fails to do so within 60 days. **If we are given incorrect or incomplete insurance information you will be billed and payment will be expected within 30 days, unless the issue is resolved.**

Patient Responsibility & Payment

Payment of copays and deductibles will be due at time of service. You are ultimately responsible if your insurance denies a claim for any reason. If you do not have insurance payment in full will be due at time of service.

Payment Options

We understand that financial circumstances vary from patient to patient. We accept payment via credit card, cash, or check. Payment for services is due at the time of the appointment.

I acknowledge that I have read and understand the payment and insurance policies outlined by Thoughtful Counseling LLC. I agree to adhere to these policies as part of receiving counseling services.

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Parent/Guardian Signature	Printed Name	Date

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PLEASE PRINT LEGIBLY

Credit Card Authorization

I acknowledge that I have read and signed the payment policies and financial agreement form for Thoughtful Counseling LLC prior to completing the credit card authorization form

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Parent/Guardian Signature	Printed Name	Date

CARDHOLDER INFORMATION (PLEASE PRINT LEGIBLY)

Name: _____

Billing Street Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Phone Number: _____

CREDIT CARD INFORMATION

Credit Card Type: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Credit Card Number: _____

Expiration Month: _____ Expiration Year: _____

Security Code (3-4 digits on back of card): _____

I hereby authorize Thoughtful Counseling LLC to charge the above-listed credit card for any missed appointments, no-show appointments, cancellations made less than 24 hours prior to the scheduled appointment, insurance co-pays, and private payment for counseling services rendered.

Card Holder Name: _____ Relationship: _____

Card Holder Signature: _____ Date: _____

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