FINANICAL AGREEMENT FORM
CareNet Counseling of Statesville/Lake Norman
Statesville, NC 28687

Client Name:_____ WI#_____

Is Client Using Insurance: Y N Company: _____

FEE INFORMATION

	1st SESSION	SUBSEQUENT SESSION	
PRIVATE PAY		45 min	60 min
Client Fee Per Session			
Fee Care Adjustment			

INSURANCE*			
Client Co-Pay			
Client Co-Insurance			
Deductible			
Estimated Insurance			
Contractual Adjustment			
EAP			

**Should Insurance decline to pay for your counseling, you will be responsible for any charges incurred. Insurance charges not paid within 60 days will become the responsibility of the client.*

CHURCH ASSISTANCE*			
Name of Church			
Church Payment			
Client Payment			
Free Care Adjustment			

**Neither Insurance nor Church Assistance funds will pay for missed/late cancelled appointments. The full charge will become your responsibility.*

I acknowledge that I am financially and legally responsible for the full payment of charges for services received in the event my health insurance claims are denied.

Client's Signature: _____ **Date:** _____

Counselor's Signature: _____ **Date:** _____