All counseling appointments are scheduled in advance. We reserve a specific time period (usually 50 minutes) to each client. It is important that you realize that a block of time has been set aside for you. If an appointment is not canceled ("No Show"), you may be charged for the time set aside for you.

Financial Agreement

____Self Pay: I do not have insurance or other third-party coverage. I will pay for the services I receive at Peace of Mind Counseling, LLC. I will make a payment of $_____ each time I come for services; if there is any balance it will be due each month.

Note: If you choose to use this Self Pay option, this clinic will not re-bill any insurance at a later date.

_____Insurance payment: I will give all insurance information required to Peace of Mind Counseling, LLC staff, including an outside billing agency, and request that they submit the charges to my insurance company for payment. I understand my insurance may not pay in full or may deny my services. I understand that I am financially responsible for all charges. This includes my deductible and/or copay. I authorize this clinic and its billing agency to furnish to my insurance company all information that may be required in order to process the claims for me and/or my dependents.

Regardless of your payment method, any uncollected balances may be forwarded to a collection agency.

Please present your insurance card at time of initial appointment and fill out the following thoroughly:

Name of Insurance: _____

Address of Insurance Company: _____

Policy ID# _____ **Group #** _____

Name of Policy Holder: _____

Address of Policy Holder: _____

Date of Birth of Policy Holder: _____**Employer:** _____

Assignment of Benefits

I hereby direct my insurance company to pay for my services by check made out and mailed to :

Peace of Mind Counseling, LLC; 115 5th Ave. So. #507; La Crosse, WI 54601

If my current policy prohibits direct payment to provider, I hereby also instruct and direct my insurance company to make the check out to me and mail it to the above address for the professional expense benefits allowable, and otherwise payable to me under my current policy as payment toward the total charges for services rendered. This is a direct assignment of my rights and benefits under this policy. I have agreed to pay any balance of said charges for professional services over and above this insurance payment. A copy of this assignment shall be considered as effective and valid as the original.

I have read and understand my Rights and Responsibilities as written in the "Client Information Booklet."

I have read and understand the above financial policy of Peace of Mind Counseling, LLC.

Client signature (if age 14 or older): _____ Date: _____

Parent or guardian signature (if client is a Minor): _____ Date: _____

For Clinical Staff use only:

Witness/Therapist Signature: _____ Date: _____

Initial Dx: _____