**On Purpose Counseling Services LLC**
**405 East Forest Street, Suite 119**
**Oconomowoc, WI 53066**

**PAYMENT AGREEMENT**

Name of Patient:_______________________________
DOB: _______________

I, ___________________________ understand and agree to the following payment agreement with On Purpose Counseling Services, LLC. My insurance company was contacted and the following was quoted as my benefits:

Name of Insurance:________________________________________

**PRIMARY**
In-Network Benefits:___________________________________________________
Deductible:___________________________ Copay:______________
Session Limits:___________ Preauthorization #:_____________________

Out of Network Benefits:_________________________________________________
Deductible:___________________________ Copay:______________
Session Limits:___________ Preauthorization #:_____________________

Benefits Reported By:_____________________________ Effective:______________

**SECONDARY**
In-Network Benefits:___________________________________________________
Deductible:___________________________ Copay:______________
Session Limits:___________ Preauthorization #:_____________________

Out of Network Benefits:_________________________________________________
Deductible:___________________________ Copay:______________
Session Limits:___________ Preauthorization #:_____________________

Benefits Reported By:_____________________________ Effective:______________


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- [x] I understand that insurance companies sometimes fail to reimburse for unexpected reasons. After 60 days from clean claim submission, if there is not a payment by insurance, I assume responsibility for what is owed and it will become my responsibility to be reimbursed by my insurance company. _______
- [x] I understand that it is my financial responsibility to inform On Purpose Counseling Services LLC, of any changes in my demographics of insurance information.
- [x] I understand that I am responsible for payment and appointments that are not cancelled within 24 hours.
- [x] I understand that my insurance company will not reimburse all services provided by my treatment provider and that my signature on this form confirms my consent to this. I understand that I have the right to revoke my consent in writing if desired:_______
- [x] I understand that I can request a written explanation of my rights as they pertain to private health information.
- [x] Co-pays, co-insurance, deductible, out-of-pocket services and/or non-covered services are due each session.
- [x] I understand if my ex-spouse holds an insurance policy on my child; consent to bill this insurance must be obtained by my office for billing proper to treatment:______
- [x] If you are a legal guardian that can make medical decisions independently and you do not wish to seek consent from the child's other parent, be advised that you assume full responsibility for the bill. Disputes over payments are not my responsibility:_______

______________________________________________

Signature of Client/Parent/Legal Guardian Date

______________________________________________

Signature of Witness Date

## Credit Card Authorization

___Amex

___Visa

___ Mastercard

___ Discover

Name on card: ___________________________________________

Credit Card Number:_______________________________________

Expiration Date:_________________

Billing Address:_______________________________________

City:_______________________ State:__________ Zip:________

I, __________________________________________________
authorize On Purpose Counseling Services, LLC to charge my credit card for my treatment sessions.

Signed _________________________________Date ___________

Witness ________________________________Date ___________


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