The CounselingNetwork
Professional Christian Counseling, Training & Education

315 Lemay Ferry Rd. • St. Louis, MO 63125 • (314) 637-7443 • Fax: (866) 695-0277 • www.TheCounselingNetwork.org

Financial Agreement and Insurance Information

Name________________________________ **Date of Birth** ______________________________

Agreement to Pay:
- I understand that I am financially responsible to The Counseling Network for services rendered.
- I agree to pay the co-pay, coinsurance, and any deductibles stipulated by my insurance plan.
- Payment is due at the time of my appointment unless other arrangements have been made.
- I understand that The Counseling Network will not deny emergency services because of an inability to pay the standard fee.
- It is my responsibility to inform The Counseling Network of any changes that affect the billing or charges to my account. This includes changes in any of my third-party payors, income or family status.
- I understand that standard collection procedures will be followed if payment is not made.

Initial for above statements __________

Standard fees and charges:
- Mental Health Individual and Family therapy, 60 minutes: $150.00
- Mental Health Evaluation, $200.00
- Psychiatric Evaluation, $300.00
- Mental Health, Group Therapy, 60 minutes: $35.00

Statement of Income:
- In order to be considered for a fee adjustment I hereby certify that my weekly/monthly/annual **gross** family income is ________________ for a family size (include self) of ____________.
- If I qualify for a fee adjustment, I agree to **provide verification of income**.
- Mental Health services must have CPC application completed to be eligible for a fee adjustment.

__________________________________ ______________________________
Client Signature/Responsible Party Date

__________________________________ ______________________________
Staff Signature Date

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Insurance Information

Primary insurance____

Insured's Name ___________________________________ Insured's Date of Birth _________________
Month / Day / Year

Insured's Address _________________________________ Insured's Phone Number_________________

______________________________ ______________________ __________________________
City State Zip code

Insured's Social Security #______________________________ Gender ☐Male ☐Female

Insured's Policy #____

Insured's Relationship to client ☐Self ☐Spouse ☐Parent ☐Other

Insured's Employer____

Employer's Address____

______________________________ __________________________ __________________
City State Zip code

Secondary Insurance____

Insured's Name___________________________________ Insured's Date of Birth _________________
Month /Day /Year

Insured's Address________________________________ Insured's phone number_________________

____________________________________ ______________________ ____________________
City State Zip code

Insured's Social Security #___________________________ Gender ☐Male ☐Female

Insured's Policy #____

Insured's Relationship to client ☐Self ☐Spouse ☐Parent ☐Other

I understand that having health insurance is not a guarantee that my condition is covered and that insurance payment will be made.

Assignment of Benefits: I authorize payment by my third-party payor (Insurance Company, Medicare/Medicaid, County, or other) to be paid directly to The Counseling Network for services rendered. I understand that I am financially responsible to The Counseling Network for charges applied to deductibles and for all charges limited by my third-party payor.

____ _________________________
Signature of Individual Receiving Services/Legally Responsible Person

____ _________________________
Staff Signature Date