Better Solutions
Counseling Center

Payment Agreement and Assignment of Benefits

Client Name: _____ Today's Date: _____

All services/counseling provided by Better Solutions Counseling Center (BSCC) are fee based and I understand that I am financially responsible for payment at the time services are provided. I also understand that it is my responsibility to schedule and keep all appointments made. In the event that it becomes necessary to cancel an appointment, I will do so as soon as possible. Appoints missed with no notice may result in a fee that insurance will not cover and becomes the sole responsibility of the client or guarantor.

Standard session fees are based on $150.00 per hour. Other services will be provided based on the current fee schedule. Insurance co-pays or deductibles are payable at the time of service.

Any questions or concerns regarding fees and/or payments should be brought to the attention of the BSCC staff immediately. Should it become necessary to secure the services of a collection agency, the client/guarantor is responsible for all fees incurred.

_____ _____
Client Signature Date

If client is a minor:

_____ _____ _____
Parent/Guardian/Guarantor Signature Relationship to Client Date

_____ _____ _____
Parent/Guardian/Guarantor Signature Relationship to Client Date

Assignment of Benefits (if not assigned, payment is due at time of service):

BSCC accepts Blue Cross/Blue Shield, UMR and Medicaid insurances, but **not** Medicare. It is the client's responsibility to inform BSCC of any changes in insurance coverage and the client is responsible to pay for any services received during a period of lapsed coverage.

The above named client currently has health insurance benefits that are assigned to Better Solutions Counseling Center. This assignment allows BSCC to release the required information to request payment for services provided. Allowable payment(s) will then be made directly to BSCC. Any unpaid portion becomes the client's responsibility. The client/guarantor is responsible to pay any deductibles and/or copayments due at the time of service.

_____ _____
Authorized Signature Date

_____ ☐ **Initial here if "Not Assigned"**
Relationship to Client

_____ _____
Therapist/Witness Signature Date