Horizon Hope Counseling, Inc.

A Place to Heal... The Courage to Change

785 Wall Street, Suite 200 • O'Fallon, IL 62269.618-367-2194.618-726-2024 Fax s www.horizonhope.org

Date of Authorization: ___________________ **Counselor/Therapist**: ______________________________

AGREEMENT FOR PAYMENT - CONSENT FOR SERVICES

The Standard Fee for a 1st evaluation appointment is $150, and the Standard Fee for ongoing counseling is $130.00 per 53 minute session. We also have Adjusted Fees for those whose income cannot support the Standard Fee. There is a 24 hour cancellation policy and you will be charged a late Cancellation Fee. The Standard Cancellation Fee is $60, or your Adjusted Fee, if it is below $60. This is necessary because a late cancellation does not allow sufficient time to fill the cancelled hour. Please complete the following information on both pages, including the signature and date on page Two, and return to your therapist.

Client's Name(s): ____SS#(s):_________________________

Address: ________________________________ City: __________________ State: ____________ Zip: _______

Cell Phone: ______________________ Home Phone: _________________ Work Phone: ______________________

Place of Employment: ____________________________ Marital Status: ______________________________

Email: ____________________________________DOB(s): _______________ Age(s): __________ Sex: M F

If Client is Minor, Guardian: _______________________ Person Responsible for Payment: ________________________

If Client is Student: ____Full Time Student ___Part Time Student ____Employed Student

Who Referred you: ___Pastor ___Friend/Relative ___Insurance ___Physician ___Attorney ____Other: ________________

Emergency Contact: ______________________________Relationship: ___________________________________

Cell Phone: ______________________ Home Phone: ___________________Work Phone: ____________________

Adjusted Fee: In order to be considered for an Adjusted Fee, you will need to provide household income information in order to demonstrate financial need. This figure to include all sources of income: (salary, child support, maintenance,).

Gross Household Income: _______________ Number in Household: __________

I would like to be considered for an Adjusted Fee: YES / NO. Based upon your income, your Adjusted Fee is: $_______________

Primary Insurance: (The office will need a copy of both sides of your insurance card.)

Primary Insurance: ____________________________________ Phone: __________________________________

Insured's Name: ____________________________ DOB: ___________________ SSN#: ______________________

Insured's Place of Employment: ____ Sex: M F

Policy#, Group #, and ID # only if we do not get a copy of your insurance card.

Policy Number:_______________________Group #:________________________ID #:_______________________

Address of Insured, if Address is different than Person attending Sessions.

Insured's Address: ____________________________ City: _________________State: ____________Zip: ________

Cell Phone: ______________________ Home Phone: ______________________ Work Phone: ___________________

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Secondary Insurance: (The office will need a copy of both sides of your insurance card.)

Primary Insurance: ____ Phone: ____

Insured's Name: ____________________________________ DOB: ________________________ SSN#: __________________________

Insured's Place of Employment: ____ Sex: M F

Policy#, Group #, and ID # only if we do not get a copy of your insurance card.

Policy Number:_____________________________Group #:______________________________ID #:_____________________________

INSURANCE BILLING: **_____YES, HORIZON HOPE COUNSELING, INC. WILL BILL MY INSURANCE AS OF ________________.**

_____NO, I AM CHOOSING **NOT** TO HAVE INSURANCE BILLED, NOR WILL I SUBMIT IT TO INSURANCE AT A LATER TIME FOR REIMBURSEMENT.

TERMS OF SERVICE

1. I am responsible for obtaining all authorizations and for all charges not covered. I will communicate with the Insurance Company and Insurance Billing Representative of Horizon Hope Counseling, Inc. to verify benefits. I understand that I am responsible for charges not covered or reimbursed by the above agents. I understand that there is a $25 fee for returned checks, along with paying for the amount of the returned check. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required and waive confidentiality for this purpose). If I have provided a Credit/Debit Card on file with Horizon Hope Counseling, Inc., I give permission to submit remaining charges not covered by Insurance, until further notice in writing.

2. I authorize Horizon Hope Counseling, Inc. staff to communicate with my insurance company for the purpose of claim verification and authorization for services, including a diagnosis code, and for may insurance carrier to release information regarding my coverage to Horizon Hope Counseling, Inc. I authorize the release of any medical or other information necessary to process this claim.
3. My right to payment for all services are hereby assigned to Horizon Hope Counseling, Inc. This assignment covers any and all benefits under private insurance, Medicare, other government sponsored programs, and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Horizon Hope Counseling, Inc.
4. Statement of Confidentiality: It is the policy of Horizon Hope Counseling, Inc. to protect the privacy of every client. Generally, no one will be given any information about either you or services furnished to you without your prior written authorization or consent. There are, however, some circumstances which require the disclosure of information without your consent. Briefly, these are:
   a) When mandated by State or Federal law. (i.e., Suspicion or knowledge of child abuse/neglect or elderly/disabled abuse/neglect)
   b) When there is an imminent risk of serious threat of physical harm to self or others.
   c) When specifically ordered by a court of law.

5. I agree that the office space of space of Horizon Hope Counseling, Inc., in some of our locations, is being provided in this facility by the sponsoring congregation, which I agree is not held liable in any way. I also agree not to hold the office space(s) of the Main office of Horizon Hope Counseling, Inc. liable in any way.

6. **IN CASE OF EMERGENCY, YOU ARE TO CALL THE LIFE CRISIS HOTLINE AT 618-397-0963, GO TO THE EMERGENCY ROOM, OR CALL 911.** Your therapist will discuss these details with you as well.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read the terms of service, and agree to accept the terms.

____ _____________________________________

Client Signature or Authorized Person's Signature Date

____

(Relationship to Client of Authorized Person)

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