Kelley Counseling

Kelley Counseling PLLC
1145 – D Executive Circle
Cary, NC 27511
919-249-5423

Financial Agreement

I _____(parent/client), agree to pay the co-pay, deductibles, co-insurance, and any past-due balance that may occur on my/my child's account that are not covered by my/their insurance benefits. I will be expected to pay by check, cash, or credit card. I further understand that if I want Kelley Counseling PLLC to file claims with my/my child's insurance company, that I am responsible for providing accurate insurance information, verifying my/my child's benefits with the insurance company, and understanding the limits of my/my child's coverage.

I agree to get preauthorization if it is required by my/my child's insurance company. I understand that I am expected to notify Kelley Counseling PLLC of any changes in insurance coverage. I agree that I will be responsible for any services and charges that are not covered in my/my child's insurance plan. I understand that any checks returned to Kelley Counseling PLLC are subject to an additional fee up to $25 to cover bank fees that are incurred.

Insurance/ Payment Authorization

In order to file your/your child's insurance for you/your child, please review the following items and check that you agree with each one"

___ I authorize the use of this form on all my/my child's insurance submissions and permit a copy to be used in place of the original.
___ I authorize release of information to all my/my child's insurance carriers.
___ I understand that I am responsible for my/child's bill and that any outstanding bills will be sent to the billing address I have provided.
___ I authorize Kelley Counseling PLLC to act as my/my child's agent in helping me/my child obtain payment from my/my child's insurance carriers.
___ I authorize payment directly to Kelley Counseling PLLC and hereby assign my right to reimbursement for the services rendered to this practice.

_____
Print Client Name

_____ _____
Client Signature Date

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Provider Date