Advance Counseling Services, LLC

Financial Agreement

I understand that it is my financial responsibility for the services rendered to me by Advance Counseling Services, LLC. In addition to all fees for these services, I authorize Advance Counseling Services, LLC to bill and collect all fees when applicable from my insurance carrier. In addition, I also understand, to bill my insurance company, that it will be necessary to release all information requested by the insurance carrier to process claims.

Other of my financial responsibilities are as follows:

Bounced checks will be charged a $40.00 fee

If an account remains unpaid for 90 days, ACS has the right to procure an outside collection agency as a means of collecting unpaid debts. All co-pays and deductibles will be the responsibility of the client (me) and paid at the time of services.

All private pays will be based on the fee given as communicated prior to first session.

Cancellations should be made within 24 hours of the session at the latest. Any cancellations made less than 24 hours of the session may be charged a $52.00 fee that the client is responsible for.

In the event that my insurance provider does not cover my sessions, I understand that it becomes my responsibility to pay for my session(s).

Your cooperation is greatly appreciated, and we thank you in advance for your business.

Client_____ Date_____

Due to financial hardships presently, ACS agrees to the reduced fee to the amount of $_____ per session for _____ months, and will be reevaluated after this time.

Client_____ Date_____

Witness_____ Date_____