NEW VISION COUNSELING CENTER, LLC
FINANCIAL AGREEMENT AND PROMISE TO PAY ACCOUNT

For in and consideration of services rendered and to be rendered to _____ (client name), I will promise to pay New Vision Counseling Center, LLC (NVCC). I understand the total charges are due when services are rendered. I agree to make available any and all insurance information to NVCC and/or billing personnel. I understand that NVCC bills from One hundred and twenty five dollars to one hundred and seventy dollars ($125-$170) for sessions lasting 45-60 minutes, based upon therapist and their licensure. I agree to provide insurance claim forms of any insurance company and/or will complete the HCFA 1500 form. I agree to assign any and all benefits to NVCC and sign in the designated areas on the insurance claim form. I agree to pay the entire deductible amount, as well as any co-payment amount due.

I understand that I am financially responsible for missed appointments, in which I do not give a 24- hour notice and that my credit card will be charged if I do not give the 24 hour notice. **The fee for a missed visit (in which less than 24- hour notice is given, including weekends) is $75.00.**

In addition, if my insurance company fails to pay for each date of service with in four weeks, I will be billed for the date of service. I will be provided with a super bill so you can be reimbursed by my insurance company. In this process, if payment is received after the four week date of service; I will be reimbursed by NVCC. By signing this agreement I completely understand that it is my responsibility to handle all insurance matters, including getting authorization and untimely payment by my insurance company (more than 4 weeks after date of service). I understand that NVCC will file each date of service one time and any rejection payment from my insurance company will be taken care of by me.

I understand that I am financially responsible for all charges not covered or denied by my insurance company. I understand that if I should receive payment from the insurance company by mistake, which payment was/should be assigned to NVCC, I will sign this payment over to NVCC and NVCC has the right to seek legal action to receive payment for this agreement, relative to payment fees, NVCC shall be entitled to reasonable attorney fees and cost of collection.

I further understand that no records (written or verbal) will be released to me or on my behalf if I have an outstanding balance due to NVCC.

NVCC does not accept checks. Please provide us with your credit card information. The card will ONLY be billed for tele-mental health services, if less than 24 hour notice is given, or on accounts that are 60 days past due:

Type of card: _____ (We only accept Visa, MC, and Discover)
Name as it appears on card: _____
Card #: _____
Exp: _____

By signing below, I am agreeing to the terms and conditions of this financial contract. I understand that if I do not provide a card number, I may be subject to pay any outstanding balance before scheduling an appointment.

_____

_____
Signature **Date**

FINANCIAL AGREEMENT AND PROMISE TO PAY ACCOUNT
Court Attendance, On-Call, and Communication with Attorneys/Other Professionals

For in and in consideration of court attendance, I _____ (**client name or guardian if minor child**) promise to pay New Vision Counseling Center, LLC (NVCC). I understand that New Vision Counseling Center, LLC bills at the rate of $200.00 per hour for court attendance. I agree to provide New Vision Counseling Center, LLC with my credit card information. I understand that the hourly rate begins when the therapist leaves their location. **I understand that a fee for two hours will be paid prior to court attendance, ($400.00) and is non-refundable if less time is needed**. If the court attendance exceeds two hours, I understand that my credit card will be billed for the remaining time. In addition, I understand that I am not paying for the therapist's testimony; I am paying for their time. Therefore, the fees are expected to be paid regardless of whether the therapist testifies or not.

On call policy:
I understand that if I request my therapist to be on-call for court attendance, New Vision Counseling Center, LLC bills at the rate of $60.00 per hour for on-call. I agree to provide New Vision Counseling Center, LLC with my credit card information in order for the payment to be charged. I understand that the hours I am requesting the therapist to be on call will immediately be charged to my credit card, and is non-refundable.

Communication with Attorneys/Other professionals/Report writing:
I understand that New Vision Counseling Center, LLC bills at the rate of $100.00 per hour for any type of communication with attorneys/other professionals/report writing (phone calls, letter writing, email, consultation, etc). I understand that I will need to provide my credit card information prior to any communication my therapist will have with my attorney/outside professional. I understand that a minimum of 30 minute increments will be billed to my credit card and is non-refundable.

Records Request
For ***each separate*** request, New Vision Counseling Center, LLC bills a flat rate of $25 for records to be copied and faxed/given to the client. If records need to be mailed, an additional fee of $10 is assessed to cover certified mail and postage. After payment is received and processed, please allow up to 7 business days for copies to be provided and/or mailed. **I also understand that no disability paperwork, work leave of absence, FMLA, etc will be completed before the third (3rd) session.** I further understand that no records (written or verbal) will be released to me or on my behalf if I have an outstanding balance due to NVCC. I understand that I am financially responsible for all charges and NVCC as the right to seek legal action to receive payment for this agreement, relative to payment fees, NVCC shall be entitled to reasonable attorney fees and cost of collection.

NVCC does not accept checks. Please Provide Credit Card Information:
Name as it appears of Card: _____

Type of Card: _____ (We only accept Visa, MC, and Discover)

Number on Card:

Expiration Date on Card: _____

By signing below, I am agreeing to the terms and conditions of this financial contract. I understand that if I do not provide a card number, I may be subject to pay any outstanding balance before scheduling an appointment.

Signature **Date**

Please read the Professional Services Agreement below then click the Submit Form button. Thank you

Submit Form