

**Consent for Payment and Cancellation Policy**

Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PMI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you self-pay? \_\_\_\_yes \_\_\_\_no

**Informed Consent & Responsibility-please read before signing**:

Financial Policy: I understand that payment is due at the time of service unless other specific arrangements are made. I also understand that I am responsible for payment of any charges or balances if third party payment is not made.

Insurance Assignment and Release: I, the undersigned, have insurance coverage, and assign directly to New Beginnings Emotional Wellness & Holistic Therapies all medical benefits, if any, otherwise payable to me for services rendered. I understand I am responsible for all charges, whether or not paid by insurance. I hereby authorize New Beginnings Emotional Wellness & Holistic Therapies to release all information necessary to process the claim and secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. Unpaid balances over 90 days will be assessed a 1.5% monthly finance charge and is also liable for all legal and collection fees.

Cancellation Policy: I understand that the time of my appointment is reserved for me. I agree to give 24-hour notice if I am unable to keep my appointment. I understand that appointments cancelled less than 24-hours prior to the scheduled time will be charged a $50 fee. Cases of extreme emergency are considered exceptions.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Self, Parent, Legal Guardian)

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Office Use Only Date\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Primary Insurance Carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy ID Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PMI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deductible? Y / N How Much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type- Per Year / Per Illness

Has it been met? Y / N

Maximum visits/year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Life-time maximum on visits? Y / N If yes, have any been used? \_\_\_\_\_\_\_\_

Percentage paid per session\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any limitations, clauses, or riders on the policy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_