Eunice Lehamcher, LISW—CP
Licensed Independent Social Worker—Clinical Practice

Payment Contract for Services

Name(s):_____
Address:_____
Street City State Zip
Bill to: Person(s) Responsible for Payment of Account_____
Address:_____

Federal Truth in Lending Disclosure Statement for Professional Services

Part One Fees for Professional Services

I (we) agree to pay _____**Eunice Lehamcher, LISW--CP**_____, hereafter referred to as the clinic, a rate of $_____ per clinical unit (defined as 45–50 minutes for assessment, testing, and individual, family, and relationship counseling). A fee of $_____ is charged for missed appointments or cancellations with less than 24 hours' notice.

Part Two Clients with Insurance (Deductible and Co-payment Agreement)

This clinic has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services:

Estimated Insurance Benefits

1) $_____ Deductible Amount (Paid by Insured Party)
2) Co-payment _____% ($_____/clinical unit) for first_____ visits.
3) Co-payment_____% ($_____/clinical unit) up to_____ visits.
4) The policy limit is _____per year: ___ annual ___ calendar

We suggest you confirm these provisions with the insurance company. The Person Responsible for Payment shall make payment for services which are not paid by your insurance policy, all co-payments, and deductibles. We will also attempt to verify these amounts with the insurance company.

Your insurance company may not pay for services that they consider to be nonefficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

Part Three All Clients

Payments, co-payments, and deductible amounts are due at the time of service.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

_____/_____
Signature(s) of Person(s) Responsible for Payment Date

Release of Information Authorization to Third Party

I (we) authorize _**Eunice Lehmacher, LISW—CP**_ to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment reimbursement directly to _**Eunice Lehmacher, LISW--CP**_

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

_____/_____
Signature(s) of Person(s) Responsible for Payment Date

_____/_____
Signature(s) of Person(s) Receiving Services Date

_____/_____
Signature(s) of Person(s) or Guardian(s) Date