4Directions Counseling, LLC
701 West Union Blvd, Suite 2, Bethlehem, PA 18018
484-894-1246 • www.4DCounseling.com

FINANCIAL AGREEMENT

I understand the charges for the services provided by 4Directions Counseling LLC for my care is my responsibility. If an insurance company is paying a portion of my bills, I understand that I must supply all the information necessary for this office to submit my bills along with any necessary forms. Any deductibles, coinsurance or charges for non-covered services will be my responsibility to pay as well. In the event that my insurance company does not pay for any charges submitted, I agree, as initially stated, to pay for all services rendered.

If payment is not made for charges which are my responsibility and 4Directions Counseling LLC refers my account to an outside collection agency, I agree to pay an ***additional 25% charge*** as a result of those collection efforts. Additionally, 4Directions Counseling LLC and/or our agents may contact you by telephone at any telephone number associated with your account. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices.

SIGNATURE _____ DATE _____

MISSED APPOINTMENTS

I understand this office has a policy pertaining to missed appointments which states that I am required to provide 24 hours notice in the event I cannot keep my scheduled appointment. If I do not provide 24 hours notice for a missed appointment, I understand that I am responsible to pay the missed appointment fee as posted in the office waiting area.

SIGNATURE _____ DATE _____

INSURANCE AUTHORIZATION

Please initial next to each statement and sign below.

_____ I request that payment of authorized insurance benefits be made on my behalf to the provider of service(s) for any service furnished to me.

_____ I authorize any holder of medical information about me to release to the health care financing administration and its agents and information needed to determine these benefits or the benefits payable to related services.

_____ I authorize that my signature on this form can be used as authorization on all insurance submissions by this provider.

_____ I hereby authorize payments to be made directly to the provider of service(s) for the medical benefits, if any, otherwise payable to me under the terms of my private group employer's coverage.

_____I hereby authorize photocopies of this form to be valid as the original.

This office does not bill Workman's Compensation Insurance or Auto Insurance companies. These cases will need to be referred to providers that specialize in these areas.

SIGNATURE _____ DATE _____