Evolve Counseling, LLC
Growth and insight through purpose -guided counseling
227500 Rib Mountain Drive Suite 101 Wausau, WI 54401
715-298-6201 www.evolvecounselingllc.com

FINANCIAL AGREEMENT FOR CLIENTS WHO HAVE INSURANCE

Client Name -including middle initial: _____
Date of Birth: _____ Social Security Number: _____
Primary Insurance (Please present your card for copying.)
Insurance Company Name _____
Subscriber Name – including middle initial: _____
Subscriber Address: _____
Date of Birth_____ Do you have secondary insurance? Yes, No
Subscriber ID# _____ Group# _____
Co-payment: _____ Have you utilized your mental health benefit this year? Yes, No

PSYCHOTHERAPY SERVICES

Insurance will be billed:

Initial Intake	1 hour	$225.00	Subsequent Individual Visit	45 min	$160.00
Subsequent individual Visit	1 hour	$180.00	Subsequent Individual Visit	30 min	$135.00

I UNDERSTAND AND AGREE TO THE FOLLOWING:

- Evolve Counseling, LLC will bill my insurance as a courtesy to me and I understand that I am ultimately responsible to pay all charges incurred. We invite you to contact your insurance provider with any questions, concerns or clarifications needed.
- Your **ACCOUNT BALANCE, co-pays, co-insurance and deductibles are** due at the time of service. **If my account reaches a balance of $200 that is not related to insurance collection, services can be suspended until the balance has been paid in full.**
- **CANCELLATION FEES: Clients will be charged *$50.00*** if an appointment is cancelled/not attended without a 24 business hour notice except in the case of an emergency.
- A **NON-SUFFICIENT FUNDS CHARGE** of $35.00 per check will be charged for any checks returned to EC. These fees are not covered by insurance and need to be collected prior to subsequent visits.
- I will be billed at the hourly cash rate of $100.00 for services that require a therapist's appearance, correspondence or phone calls related to legal, medical, educational or psychological assessments. Insurance does not cover these fees.

My signature verifies that I understand agree to pay for charges incurred by myself, or my child. I agree to pay the portion not covered by my insurance company or EAP on the date that counseling services are rendered. I understand that this is a contract for services. I have read this information and I understand and agree to follow the policies listed above. I hereby authorize Evolve Counseling, LLC to bill my insurance carrier for the services that I and/or my family members receive. Evolve Counseling, LLC reserves the right to unsolicited discharge from treatment.

Signed: _____ Date: _____
(Client or Responsible Party)
Signed: _____ Date: _____
(Evolve Counseling, LLC Staff)