FINANCIAL AGREEMENT AND INSURANCE INFORMATION

Client Name: ____

Date of Birth: ____

Social Security number: ______________________________________

If we are in your insurance provider network, your insurance will pay a fee negotiated by your insurance. You can expect your portion to be your typical copay. If we are providing services using your insurance for out of network benefits, the exact breakdown of your portion of the service will vary based on your specific plan. We encourage you to check these benefits by calling the number on the back of your insurance card. Typically insurance companies have been very responsive to their own client inquiries. If you have questions, we would be happy to assist you. For individuals paying out of pocket, the following rates are standard. Individual clinicians may provide a sliding scale based on financial need, please inquire with each clinician.

FINANCIAL AGREEMENT

Standard Fees and Charges

- Individual & Family Therapy, 16-37 minutes: $150 or rate negotiated by insurance
- Individual & Family Therapy 38-52 minutes: $175 or rate negotiated by insurance
- Individual & Family Therapy, 53-60 minutes: $190 or rate negotiated by insurance
- Individual Mental Health Assessment: $235 per intake, or rate negotiated by insurance

Agreement to Pay:

- I understand that I am financially responsible to my provider for services rendered.
- I agree to pay the co-pay, coinsurance, and any deductible stipulated by my insurance plan.
- Payment is due at the time of my appointment unless other arrangements have been made.
- It is my responsibility to inform my provider of any changes that affect the billing or charges to my account. This includes third-party payers, income, or family status.
- I understand that standard collection procedures will be followed if payment is not made.

I agree to the above statements: ______________________________________

216 Green Bay Road • Suite 108
Thiensville, Wisconsin 53092

Insurance Information

Primary Insurance: ____________________

Policy Number: ____________________

Insured's Name: ____________________

Insured's Date of Birth: ____________________

Insured's Address: ____________________

Insured's Phone Number: ____________________

Relationship to Client: ☐ Self ☐Spouse ☐Parent ☐Other

Insured's Employer: ____________________

Employer's Address: ____________________

Secondary Insurance: ____________________

Policy Number: ____________________

Insured's Name: ____________________

Insured's Date of Birth: ____________________

Insured's Address: ____________________

Insured's Phone Number: ____________________

Relationship to Client: ☐ Self ☐Spouse ☐Parent ☐Other

Insured's Employer: ____________________

Employer's Address: ____________________