



Chuck Britt, MA, LMFT

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WELCOME TO OUR SERVICES

Section 1 – BASIC FINANCIAL AGREEMENT

Chuck Britt's STATEMENT: When I schedule an appointment with you at your request I am setting aside a part of my schedule to do important work for you. Being in therapy is hard work for you. Providing you with quality service and creating a safe place to do difficult work is my job. As a professional, I take this responsibility very seriously.

CLIENT'S STATEMENT: Every time I choose to schedule a session with Chuck Britt, MA, LMFT, I understand and agree that I am personally responsible for paying Chuck Britt's fees as detailed below. I agree to pay even if the third party payor refuses to pay for the service. I understand that if I do not pay for scheduled services in a timely manner my account may be sent to collection. I understand that I am also responsible for any additional costs for collection if necessary.

PRIVATE PAY AGREEMENT (No Third Party Payor.) (Discounts are available for full payment at the time of service.):

I agree to pay \$_____ before the first (Assessment) session and \$_____ before each subsequent session. **OR**

I agree to pay above fees at \$_____ per month until all fees have been paid in full. (1st pmt at the 1st session.)

THIRD PARTY PAYOR: (PLEASE PROVIDE YOUR INSURANCE CARD.) If you provide a valid insurance card we are happy to electronically submit your claim for payment. We agree to accept your insurance company's "Allowable" limitation. YOU are responsible to pay for all copay, deductible and patient responsibility charges within the Allowable amount. If your insurance refuses to pay for any reason you are responsible to pay for services at our regular rates: (\$125.00 for the first session. \$85.00 for subsequent sessions.)

Insurance * _____, ARIS or Skagit County , Tribal

Our electronic insurance processing and billing service will process all personal information confidentially.

COPAY:

Until the amount of Copay is verified with the insurance company a **40.00 payment** is due at the beginning of each session.

(Please pay in advance on line or have your cash or check ready.) Overpayments will be reimbursed at the end of treatment.

NO SHOWS AND LATE CANCELLATIONS:

Third party payors will not cover any part of the cost of an appointment that is either missed or canceled with less than 24 hours notice. I agree that I will pay **\$60.00** for each missed appointment and each appointment canceled within 24 hours of the scheduled time.

CREDIT CARD PAYMENT:



I understand that I can pay for full sessions & copay on line. See the **PAYMENT** link at: www.selftimeout.com

Section 2 - PATIENT INFORMATION

The following information is needed to meet State information and Insurance requirements:

Name _____ Date Of Birth _____ - _____ - _____ Age _____ Gender M of F
Address _____ City _____ State _____ Zip _____
Home _____ - _____ - _____ Work _____ - _____ - _____ Mobile _____ - _____ - _____
SSN _____ - _____ - _____ EMAIL ADDRESS: _____ (Ask for Discount!)

Section 3 - PARENT AND/OR GUARDIAN INFORMATION (If the Patient is under 13 years old.)

Name _____ Date Of Birth _____ - _____ - _____ Age _____ Gender M of F
Address _____ City _____ State _____ Zip _____
Home _____ - _____ - _____ Work _____ - _____ - _____ Mobile _____ - _____ - _____
SSN _____ - _____ - _____ EMAIL ADDRESS: _____ (Ask for Discount!)

Section 4 – PATIENT/GUARDIAN COMMITMENT TO PAY

SIGNATURES: I understand that by scheduling any session with Chuck Britt, MA, LMFT I am committed to promptly pay all fees detailed above.

Patient or Guardian: _____ Date _____ - _____ - _____

Patient or Guardian: _____ Date _____ - _____ - _____