HYLAND PSYCHOLOGICAL SERVICES, INC. FINANCIAL AGREEMENT

A. Client Information

_____

Last Name, First Name, Middle Initial

_____/_____/_____/_____/_____

Social Security Number Date of Birth

_____

Address City State Zip

(_____)_____(_____)_____(_____)_____

Home Phone Work Phone Cell Phone

_____

Name of Person Responsible for Bill (If different from above) Relationship to Client

_____/_____/_____/_____/_____

Social Security Number Date of Birth

_____

Address City State Zip

(_____)_____(_____)_____(_____)_____

Home Phone Work Phone Cell Phone

B. Client Responsibilities

I understand that I, not my insurance company, am responsible for payment of all fees for services rendered by Hyland Psychological Services, Inc. and that payment is due at the time services are rendered.

I understand that I am responsible for checking with my insurance company for verification of benefits including: coverage, deductibles, co-pays, and number & types of sessions (individual therapy vs. family therapy vs. couples counseling) allowed. I understand that Hyland Psychological Services does not file insurance and is not an in-network insurance provider. If I choose to file out-of-network claims, HPS will provide me with the necessary receipts to submit to my insurance company.

I understand that I must provide 24 hours notice cancellation if I need to change an appointment, and that failure to provide such notice will result in my being charged for the appointment that was missed.

I understand that during the course of therapy it may become necessary to increase fees to compensate for increased costs and inflation. Fees will be reviewed periodically and will be increased no more than once during any calendar year.

I certify that, to the best of my knowledge, these forms have been completed accurately and that I understand and accept my financial responsibilities.

_____ _____

Signature of client or Authorized Representative Date

Printed Name