ATLANTIC COUNSELING & CONSULATION, INC.
Psychotherapy /
Medication Consultation

INSURANCE AUTHORIZATION AND FINANCIAL AGREEMENT:

I hereby authorize the provider of services to furnish information to insurance carriers concerning my condition and treatment. I hereby assign to the provider all payments for medical services rendered to my dependents or myself.

As a courtesy, Atlantic Counseling & Consultation will check your benefits with the insurance company however; it is recommended that you contact your insurance company as well to confirm your behavioral health coverage.

I understand that it is my responsibility to know my insurance benefits and that I am responsible for copays, coinsurance and/ or deductibles that are required by my insurance plan.

I understand that it is my responsibility to obtain prior authorizations, if applicable, from my insurance company for services at Atlantic Counseling & Consultation, Inc.

I understand that it is my responsibility to provide Atlantic Counseling & Consultation, Inc. with accurate and up to date information about my insurance coverage at the time of the visit. I understand that failure to do so may result in non- payment from my insurance company. I understand and agree that I am responsible for full payment of any services not covered by insurance.

CANCELLATION POLICY:

24-hour notice is necessary to cancel any appointment or you will incur a charge of $90.00 for the late cancel or missed appointment (please refer to page 2 of the Patient Agreement)

Signature:_____ **Date:**_____