

Payment Agreement

PRIVATE PAY

Payment at time of service is appreciated, and a 25% discount is offered when full fee is paid at time of service.

- By checking this box I agree to pay full fee for services, and understand no information will be released to a third party (e.g., insurance provider) for billing purposes.

While this document does not obligate me to receive services, I understand that should I receive services, my signature on this document implies it will be treated as a contract. Accounts that become delinquent without payment arrangements will be referred to collections either through a third party collection company or through small claims.

INSURANCE PAY

- By checking this box, I understand that my insurance company will be billed at the full fee rate. I will be responsible for any amount not paid by the insurance up to co-payment amounts or percentage of the unit fee.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

- By checking this box, I understand that my EAP company will be billed at the contracted rate, and authorize Laura Doughty, M.S., LMHC to release information as required to comply with EAP contracted services. I understand that I will not be billed for services provided under my EAP program.

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize payment of benefits to be made directly to Laura S. Doughty, PLLC for services provided. I authorize Laura S. Doughty, PLLC to release information on my behalf to facilitate third-party payment for service I have incurred. I understand that I am financially responsible for any charges not covered by this assignment, except where expressly prohibited by EAP contract.

Client Signature (or guardian)

Date

Client Name (please print)

Phone Number

Home Address

Name of Employer

Client Social Security Number

Client Date of Birth

Name of Insurance

Insurance ID#

Ins. Contact Phone

Name of Insured (if not client)

Insured's SSN

Insured's DOB

Insured's Address

Insured's phone

Insured's Employer