FINANCIAL RESPONSIBILITY FORM **PLESHE COUNSELING SERVICES LLC, KAREN PLESHE MSW**

Patient Name: _____ Patient DOB: _____ Todays date:_____
Spouse or Legal Guardian (When applies): _____ DOB: _____
Address: _____
Phone (Primary): _____(Mobile): _____ Work:_____

CREDIT POLICY

Fees for services are your responsibility. As a state licensed clinical social worker, Karen Pleshe MSW, LCSW, is eligible to bill your insurance for services rendered. It is recommended, however, that **PRIOR** to beginning treatment, clients contact their insurance company to determine what coverage is available and if pre-authorization, precertification, or special EAP referral is necessary. **All referrals or prior authorizations need to be obtained, by you, prior to your first visit. We request at the time of service to satisfy your deductible or co-pay portion. This applies to all patients, whether new or established.** Clients are responsible for the timely payment of their account. **Co-pays are due at the time of service.** If you are unable to clear your balance within 30 days, $50.00 or more per month (depending on the amount owed) will be required as a monthly payment, unless prior financial arrangements have been made with our credit department. A late payment fee of 1.5% monthly may be assessed. We urge you to notify us if you have temporary financial problems to help us avoid other methods of collection.

Your provider does not accept Medicare or Medical Assistance/HIRSP as insurance. We will not send claims to Medicare or Medical Assistance. You are not allowed to send claims to Medicare or Medical Assistance for services received by your provider. Any exception to this policy requires a written agreement with your provider and to be placed on file in the Patient Account Office.

It is understood and agreed that all fees for any legal testimony or reports that may be requested of or demanded of your provider as a result of being involved in a patient's case will be the responsibility of the patient. This will be billed at the provider's usual and customary legal fees and will not be billed to insurance. I agree to accept any and all responsibility for these fees.

The undersigned agrees to the above Credit Policy.

_____ _____
(Signature) (Date)

I, the undersigned, certify that I (or my dependent) have insurance covered with_____
(Insurance Carrier)

And assign directly to Karen Pleshe MSW, LCSW all insurance benefits, if any, otherwise payable to me, f0r services rendered. I understand that my provider does not accept Medicare, Medical Assistance or HIRSP as insurance and that my provider will not send claims to Medicare, Medical Assistance or HIRSP for services I receive from my provider. Any exception to this policy requires that a written agreement with my provider be on file in the Patient Accounts office.

I understand and agree that I am financially responsible for all charges, legal or clinical, whether or not paid by insurance. I hereby authorize the provider to release any and all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance claims (manual or electronic).

I have read the above statement entirely and understand my financial responsibility for all services provided by Karen Pleshe MSW, LCSW. I have been informed of the below fees and agree to them.

_____ _____
(Signature) (Date)

PROVIDER RATES PER SESSION

INITIAL ASSESSMENT	60 MIN	$185.00	INTAKE REOPEN (AFTER 9 MOS)	$175
ONGOING THERAPY	55 MIN	$160.00		
NO SHOW/LATE CANCEL	$85.00 (not billable to insurance)		Records/administration copying	$26