**ROBERT FORTE LPCC, Ltd.**

**Financial Policy and Consent to Treatment**

My fee is $100.00 per session. Payment including co-payments are expected at the time of service by cash or personal check. If I am a participating provider, my office will bill your insurance company for the portion of the fee which they agree to cover. Insurance coverage is an agreement between you and your insurer. You are responsible to follow up on any unpaid fees billed to your insurance.

If you plan to use insurance as partial payment, you are responsible to provide the following information at the initial session.

- Name of your insurance company and billing address.
- Status of any deductible amounts which must be met before your insurance company will make payments toward session fee.
- Present your insurance card to Bob Forte.

If you are not certain of your deductible status, session fee is due at the time of service. Your signature below indicates you have checked with the insurance company and have been told current deductible has been met.

Signature ________________________________________________

If you have not signed, A fee of $100 is due at the time of the session.

If you are utilizing your EAP, you must call the EAP in advance to have the payments approved. At the time of your first session, you must provide proof of authorization of EAP services, number of sessions approved and billing address of your EAP.

My authorization number is ______________. Number of sessions approved is_______.

Missed appointments cannot be billed to your insurance or EAP. Unless cancelled 24 hours in advance, you are responsible for session fee for all missed appointments. Cancellations and requests for changes in appointment time must be made by calling and leaving a cancellation message at 614-436-6080 ext. 2. Do not use email. Session fees, co-payments and missed appointment fees are your responsibility and must be paid to avoid formal collection efforts.

*Agreement and Consent to treatment. I have read and understand this financial policy, have had my relevant questions answered and agree to treatment and to the release of information necessary for billing for services. I accept, understand and will abide by terms of this agreement and I consent to treatment by Robert Forte LPCC, Ltd.*

**X____________________________________________ Date_________________________**

**Signature of patient**