Payment Agreement Form

Adam Woodruff, MS, LMFT, CAS
1361 Francis Street, Suite 102, Longmont, CO 80501
Cell: (720) 270-2058
Email: therapy@adamwoodruff.net
Website: adamwoodruff.net

Primary Insurance Information

Insured's Name _____

Insured's birth date _____

Employer _____

Insurance company name _____

Client's Relationship to Insured:

☐ Self ☐ Spouse ☐ Dependent

ID # _____

Group # _____

Secondary Insurance Information

Insured's Name _____

Insured's birth date _____

Employer _____

Insurance company name _____

Client's Relationship to Insured:

☐ Self ☐ Spouse ☐ Dependent

ID # _____

Group # _____

Provider Phone #: _____

I have discussed and agree to the following financial payment and collection procedures with my therapist:

1. The standard fee is $140, per 50-minute session.
   Alternate payment plan: ☐ Mr. Woodruff will bill insurance according to policy.

   Other:_____

2. Upon verification of health plan/insurance/other third-party payer and policy limits, the insurance carrier will be billed for the client, and I will collect directly from the carrier. Client will be responsible for all deductibles and co-payments. Co-payments are due at the end of each session. **If client is not covered at the time services are rendered, they are responsible for full payment at my current full rate**.

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3. Payment is expected at the end of each session, unless the client has made prior arrangements with the therapist as specified above.

4. Appointments are reserved for the client. A fee will be billed to the client for cancelled appointments. This fee cannot be billed to insurance or other third parties. Cancellation *without* 24 hours' notice will be billed $140 or the reimbursement rate of your policy.

5. A $30 dollar service charge will be added to all returned checks and must be paid at the next session.

6. Unless otherwise arranged, telephone calls exceeding 10 minutes will be prorated and billed based on the hourly fee for therapy and must be paid at the next session.

7. In the event the client does not pay their bill within 60 days, the account will be turned over to a collection agency. At that time information, including name, address, DOB, and employment information will be released to the collection agency in order that they may collect.

8. Signing below authorizes the release of information regarding client care to their health plan for the payment of claims, certifications/case management decisions, and other purposes related to the administration of benefits for their health plan.

I understand the above payment procedures and agree to the details included.

_____ _____

Client Signature Date Printed name

_____ _____

Client Signature Date Printed name

_____

Therapist Signature Date