TPC
Integrative Psychotherapy & Pastoral Counseling

Web tripastoralcounseling.org
Phone 919.845.9977
Fax 919.845.9761

Name: _____

FINANCIAL AGREEMENT

As a non-profit agency, TPC attempts to make counseling affordable by joining insurance provider panels and by using an adjustable fee scale for clients who do not have insurance. Fees will be discussed during your initial contacts with one of our therapists. We can file insurance, but coverage varies according to each insurance plan. We encourage you to check with your carrier in advance to verify your mental health/behavioral health coverage. Our therapists are "In-Network" providers with Blue Cross and Blue Shield of NC. Each therapist may also participate in or are out-of-network on other insurance panels.

For those who are not using insurance, we can use an adjustable fee schedule based on income. In the event someone with no insurance coverage cannot afford the minimum amount on the adjustable fee scale, TPC has two funds that offer short-term assistance to those who qualify. These funds are contingent on several factors and your therapist will discuss these with you if appropriate.

Payment is expected at the time of service unless arrangements are made in advance with the therapist. We accept cash, check, MasterCard, Visa, and Discover.

FEES: Fees range from $60-$160 per session. Fees can vary depending on type of therapy and length of session. Fees for other services (letters, phone calls, consultations, etc.) vary for each therapist and will be discussed as needed.
Your Fee is _____ per session.

NOTE: We realize that, on occasion, you may not be able to make a scheduled appointment. Please notify us as soon as possible if you will need to cancel or re-schedule an appointment. Please remember your appointment time has been reserved for you alone so you may be charged a fee **for missed or canceled appointments if you do not provide 24-hour advance notice. This fee is _____**

Please also be aware your therapist may not be able to reserve a regularly scheduled appointment time for clients who frequently cancel, re-schedule, or miss appointments, especially without giving 24-hour notice. Please also note your therapist may ask to keep a credit card number on file to charge for missed appointments.

INSURANCE INFORMATION (Your responsibilities include):

- **Verify your plan's limitations, deductibles and exclusions, prior to your first appointment.** It is important you understand your benefit coverage. For benefit coverage questions, please call the customer/member service phone number on the back of your insurance card. You will receive an Explanation of Benefits (EOB) from your insurance company detailing charges, amounts you are responsible for, and amounts they have paid.
- **Pay your fee for services at the time they are rendered.** In compliance with health insurance contracts, TPC requires all co-payments are collected at the time of service. This includes payments towards co-insurance and deductibles. In some cases, the co-insurance/deductible amount collected will be an estimate and adjustment will be made once a response is received from your insurance company regarding the claim. This may result in a credit to your account or additional charges. **We do not have the option to waive co-payments, deductibles, or co-insurance amounts due** as that would be a violation of the contract we have with the insurance company.
- **Provide us with a copy of your card and update us if any changes occur in your coverage**. Please also notify us of any changes in address or other contact information. If the insurance information you provide to us is later determined to be inaccurate, resulting in a denial of your claim, you will be responsible to pay the amount denied by your carrier.

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BILLING INFORMATION (Attach copy of insurance card if filing insurance)

CLIENT NAME:

_____ _____ _____
First Name Last DOB (mm/dd/yyyy)

_____
Address City State Zip Code

_____ _____
Name of Insurance Company Policy Number **(Subscriber or Recipient ID #, Suffixes)**

_____
Policy Holder's Name DOB (mm/dd/yyyy) Relationship to Client

_____
Address (if different than above) City State Zip Code

_____
Social Security Number (person responsible for bill)

_____ ☐ Home ☐ Mobile ☐ Work ☐ Other
Phone Number

REQUIRED SIGNATURES

I have read, understand, and agree to TPC's Financial Agreement. I understand I am ultimately responsible for payment to TPC, Inc. for any and all services rendered and that such payment is due at the time of the visit. My signature below indicates I fully understand and agree to these terms.

Signature _____
(Person responsible for payment) Date

I authorize TPC to release any medical information to my insurance company which may be deemed necessary to process an insurance claim. I authorize my insurance company to assign benefits to TPC. I understand I am responsible for payment for services rendered by TPC regardless of reimbursement for these services by the insurance company and any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify TPC immediately whenever there are changes in the client's health condition or health plan coverage in the future.

Signature _____
(Required to bill insurance) Date