929 S Washington St Junction City, Kansas 66441
785.802.9024
Tessa.Gutierrez@newleafcares.com

PAYMENT AGREEMENT

Client Name:_____

☐ I elect to have services billed through insurance. (Complete Shaded Area Below)
☐ I elect to pay full fee for my services at a fee of $125 per hour.
☐ A second party has agreed to pay for my services at a fee of $125 per hour.

****

INSURANCE & BILLING AUTHORIZATION (complete only if billing insurance):

Policy Holder's Name:_____

Policy Holder's Address (if different):_____

_____

Policy Holder's SS#_____ **Policy Holder's DOB:**_____

- I hereby authorize payment directly to New Leaf Counseling, for any insurance due to me for reimbursement of claims for services provided. I agree to pay my share of fees at the time of receiving the monthly statement.
- I understand that I will be billed $30 for any appointments cancelled without 24 hours advanced notice, and that these fees will not be submitted to insurance.
- I authorize New Leaf Counseling to disclose to my insurance company the diagnosis, dates of services, type of treatment, and any other information from my records that is required for processing my insurance claims. This can include treatment notes and the entire record, if requested. If submitted for review, I understand that the records may be scanned and kept on file at BCBS or other contracting insurance managed care companies.
- I understand that if I default on payment of debt, I am authorizing release of my name and payment record to legal services needed to collect this debt, I and understand that may become public record if legal action is initiated.

929 S Washington St Junction City, Kansas 66441
785.802.9024
Tessa.Gutierrez@newleafcares.com

- I understand that any mental health diagnosis may require New Leaf Counseling to consult with my primary care physician or psychiatrist unless I waive that requirement.

_____ I agree to waive that requirement. (Initials)

_____

Signature of Client or Legal Representative Date

_____

Tessa Gutierrez, LSCSW, LCAC