Patti Bear, Licensed Professional Counselor

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Insurance/Fee Agreement

Client Name: ____ Date of Birth: _____________

Responsible Party: ____

_____I have insurance and would like my mental health treatment billed to:

Insurance Company: ____

ID# ____ Group # _________________________

Name of Insured: ____

DOB of Insured: ________________________ Client Relationship to Insured: Self Partner Child

I agree to pay copays/deductibles according to my insurance requirements at the time of service.

_____I do not have insurance/do not want my mental health treatment billed to my insurance. I agree to pay for each counseling/therapy session at the time of service.

I understand that I am responsible for any fees incurred, and that insurance is billed as a courtesy. I agree to pay for services rendered, including services that are not covered by my insurance company. I understand that failure to pay for services may limit the services that I receive.

____ ___________________

Client/Parent/Guardian signature Date