Deb Christiansen Counseling

MS, LMHP, PLADC
9300 Underwood Avenue, Suite 240
Omaha, NE 68114

Name: _____

Insurance Coverage:

- Client agrees to contact Insurance Company to verify Mental Health benefits. You pay for your insurance. It is your responsibility to know the benefits of your policy. _____ (Initial)
- Should a dispute arise on a claim, **it is generally the clients' responsibility to clarify and resolve the dispute with the Insurance Company.** ____ (Initial)
- If insurance is being file, any deductible not yet met is **due at the time of service as well as any co-pay.** ____ (Initial)

Payment:

- If Insurance is no being filed, payment is expected at the time of service. ____ (Initial)
- The clients agree to pay a no-show charge of **$50.00** if the session is cancelled in less than 24 hours or the clients fail to attend the session without notice. ____ (Initial)
- A service requested by the client, but not covered by the client's Insurance Plan (i.e. letters, forwarded records, etc.) will be assessed a charge of $50.00 per request.
- Phone calls are not billable to your insurance. Phone calls over 10 minutes are billed for the amount of time spent on the phone, at the pro-rated hourly rate. ____ (Initial)
- Email and phone calls will be responded to within 72 hours.
- Fees are subject to change at the discretion of the practice. A fee schedule is available upon request. ____ (Initial)
- There is a $20.00 administration fee for checks that do not clear the bank. (Initial)
- Questions regarding your account should be directed to Midwest Medical at (402) 709-0063 or midwestmed@cox.net. ____ (Initial)

I certify that I have read, understand and agree to the foregoing. The undersigned is the client or is duly authorized by or on behalf of the client to execute the above and accept its terms.

_____ _____

Signature of Client or Responsible Party **Date**

_____ _____

Signature of Witness **Date**