Payment Agreement

While this document does not obligate me to receive services, I understand that should I receive services, my signature on this document implies it will be treated as a contract. Accounts that become delinquent without payment arrangements will be referred to collections either through a third party collection company or through small claims.

PRIVATE PAY

Payment at time of service is appreciated, and a 25% discount is offered when full fee is paid at time of service.

☐ By checking this box I agree to pay full fee for services, and understand no information will be released to a third party (e.g., insurance provider) for billing purposes.

INSURANCE PAY

☐ By checking this box, I understand that information will be released to my insurance company for the purpose of making claims for services provided. I will be responsible for any amount not paid by the insurance company, as allowed by provider contract.

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize payment of benefits to be made directly to Laura S. Doughty, PLLC for services provided. I authorize Laura S. Doughty, PLLC to release information on my behalf to facilitate third-party payment for service I have incurred. I understand that I am financially responsible for any charges not covered by this assignment, except where expressly prohibited by provider contract.

Employer Providing Coverage: _____

Health Insurance Company: _____

Employee Name: _____Employee Date of Birth: _____

Employee Insurance ID Number: _____ Group No: _____

Client Relationship to Employee: _____

_____ _____

Client Signature (or guardian) Date

_____ _____

Client Name (please print) Phone Number