Dianna Jurena Counseling

Important Information about Payments

*Payment for services rendered is the responsibility of the individual client. You have options. Please initial beside your choice on only one line.

____ 1. I will pay $125.00 by cash, check or credit card before each session.

____ 2. I will pay the co-pay before each session and my insurance will be billed.

____ 3. I choose to use a payment plan to be discussed with my therapist. I will pay $______ of each session costing $_______ charged at the time of the session. The remaining $_______ per session will be added to my account and will be paid off after counseling is completed. I will then begin to pay off the balance commencing immediately after the last session. The remaining balance will be paid off at the rate of $______ per week until it is paid off.

*Missed appointments – Please note: I am privileged to be able to work with you towards your improved quality of life. I value our time together. Additionally, I request the same valuing of my time from my clients. Thus, a 48 hour cancellation notice is required except in the cases of genuine medical emergencies or significant inclement weather. We cannot bill insurance for missed appointments. Please come to your sessions with your schedule in mind. If a 48+ hour call is not made to notify me of your need to miss your appointment, your account will be charged a $75.00 fee. This will help to enable me to continue working as your therapist and to remain in business. Thank you for your understanding of this necessary policy.

*Credit Card Payment Authorization – Please complete and sign this portion of this section to authorize Dianna Jurena Counseling to debit your credit or debit card. By signing this form you give us permission to debit your account on or after the applicable session date of service. Please complete this section whether you are normally paying with cash, check, credit or debit. Payment is required at the time of your session. Please complete, sign and initial the information below.

I ___________________________ authorize Dianna Jurena Counseling to charge my _____ credit card or _____debit card account indicated below:

Please initial ~

___ payment for session

___ cancelation fee

___ co-pay if payment is made by insurance.

___ Please use my debit card. Owners information:

Billing address ____

Phone numbers ____

Email address ____

*Credit Card Guarantee for Personal Balances – As a courtesy to you, we will bill your health insurance if you have chosen that route of payment. We will wait up to 60 days for payment. Please remember that ultimately you are responsible for payment. On day 60, if your insurance has not yet reimbursed for your services, we will charge your credit card for the amount of the session. Any payments made later than 60 days by the insurance company will be immediately refunded to you.

_______________________________________ _____________

signature date

*First Time Clients – A first time client will be asked to hold their first appointment time by credit card that will be charged $75.00 if they do not show to their first appointment and do not call to cancel. This is non-refundable.

*I understand and accept responsibility for any debt for services rendered to me by Dianna Jurena LPC.

______________________ ______ ___________________ ______

signature date Dianna Jurena date