



THE RELATIONSHIP CENTER

Branson • Springfield

Phone: 855.593.4357 • Fax: 417.763.3331 • www.TRCHelps.com

“Biblically Christian, Clinically Proven”

FINANCIAL RESPONSIBILITY STATEMENT

Name: _____ SS# or Drivers Lic. # +State: _____

Session Fee: \$ _____ Weekly Payment Arrangement: \$ _____

Financial Policies

- I agree to be responsible for the charges I incur as a result of counseling and/or assessment.
- I understand that charges are based on the amount of professional time used / reserved for me by my request **regardless of whether I appear for my session or not.**
- I understand that all payments are due at the time services are rendered.
- I understand that if I am approved for a **weekly payment arrangement** that I will be invoiced for the full amount of my session and payments will be drawn until my balance is satisfied.

Fees

Psychologist - \$125 | LPC Specialist - \$125 | LPC - \$95 | PLPC - \$75 | Intern - \$50

In addition to the standard session fee, all 1st session appointments will be charged a one-time \$30 assessment and setup fee.

Cancellation Policy

I understand that if I fail to give notice of cancellation by 5 pm the business day before my scheduled appointment, my credit or debit card will be charged for the time I have requested be reserved for me.

The charge will appear on your bill as coming from: TRC.

Name on Card		Card Type	
Credit Card Number			Expiration Date
Billing Zip code		Security/CSC # (3 digit # on back of card)	

Authorization:

I hereby authorize **The Relationship Center** to charge the indicated credit card. I guarantee and warrant that I am the legal cardholder for this credit card and that I am legally authorized to enter into this agreement.

Signature of Card holder (Required): _____ **Date:** _____

Insurance Processing:

- I understand I will receive a receipt suitable for submission to my insurance company for reimbursement or upon my request TRC can file claims with my insurance for a **\$5 fee.**
- I understand that TRC does not accept assignment for healthcare insurance benefits and has no control over how much reimbursement I may or may not receive from my insurance company.

I wish for TRC to process my insurance claim and have attached the **Insurance Claim Processing Request Form.**

By signing below I testify that I have read and understand the above financial policies and do hereby agree to fulfill my financial obligations as so stated.

Printed Name	Signature of Client or Guarantor	Date
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