Healing Path counseling

Brigid Zarbock, PsyD
Shannon Merkin, LCSW, PMH-C
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1010 Jorie Blvd
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2100 Manchester Rd.
Bldg C, #1620
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10540 S. Western Ave.
Suite 312
Chicago, IL 60643

p.630-296-7449
f.630-296-7532

Credit Card Guaranty of Payment

I understand that Healing Path Counseling, LLC (HPC) will be billing my insurance carrier for therapy and or/evaluative services. I further understand that I am responsible for all reasonable and customary fees that my insurance carrier *does not cover*, such as deductibles or co-payments. It is my responsibility to know my benefits and to follow up with any insurance disputes. If disputed due to the failure of the insurance company or me, then payment becomes my full responsibility.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim.

You are responsible to keep your credit card information up to date.

I understand that I will be charged a fee of $100 for a failed appointment and an $80 fee for appointments cancelled with less than 48 hour notice.

The function of the card on file to ensure outstanding balances are paid. You will be notified via invoice, verbal discussion, or electronic correspondence, or any other means of communication, when the card will be charged and the amount that will be charged. If we have agreed your card will be charged when there is a balance you will not be reminded each time.

Account Type: _____VISA_____MasterCard_____AMEX_____Discover

_____HSA *(only used for services, need separate card for fees on file)***

Cardholder Name_____

Billing Address_____

ZIP Code_____

Account #_____

Expiration Date_____

*****CVV2 (3 digit number on back of VISA/MC/Discover, 4 digits on from of AMEX)**_____

_____ **Date**_____
Signature of Client

_____ **Date**_____
Provider

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Payment Policies

I authorize Healing Path Counseling, LLC, to bill my insurance carrier, if they are in-network providers with my insurance. I understand they require some clinical information, such as diagnoses. I instruct that payments be made to Healing Path Counseling, LLC.

Although, Healing Path Counseling will be billing my insurance, I understand that I am responsible for all reasonable and customary fees that my insurance carrier does not cover, such as deductibles or co-payments, fees for services not covered, out of network fees. I understand that it is my responsibility to know my benefits and to follow up with any insurance disputes. I understand that if coverage is disputed due to the failure of the insurance company or myself, then payment becomes my full responsibility.

I understand that I must put a valid credit card on file and this will be my main form of payment, unless discussed otherwise. When I incur a balance, I understand that HPC will charge this card (this may be for co-payment, fees not covered, etc.)

I understand that if my account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, HPC has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim and I will be responsible for this.

I understand that I will be charged a fee of $100 for a failed appointment and an $80 fee for appointments cancelled with less than 48 hour notice.

A note from Healing Path Counseling, LLC: This cancellation policy is really important for our counseling practice because, while a medical doctor can see 35 patients in a day, a therapist, like ourselves, generally see a maximum of 6-8. We reserve for you, and all of our clients, a full hour of our time for the appointment and clinical notes. If a client cancels with less than a full 48-hour notice, it is highly unlikely we will be able to fill that time slot, and we lose an entire hour from our work schedule. We want you to know that our cancellation policy is not a penalty or a punishment. We know that life happens! In return, our clients understand that scheduling an appointment with us is like buying a ticket to something. Without 48 hours in advance, you might not be able to get a refund for that ticket, no matter the circumstance. We appreciate your understanding! By signing, you acknowledge you understand the purpose of the cancellation and no-show policies.

Name of Client/Insured (Print)_____

_____ _____
Client Sign Here Date

_____ _____
Responsible party please sign here (self, guardian, parent) Date

_____ _____
Provider Date