

Elizabeth Poole, LPC
6970 S. Holly Cr. Suite 204
Centennial, CO. 80112

Counseling Financial Agreement

The Counseling Financial Agreement is part of the counseling and Fee Policy Agreement between _____ (client) and Elizabeth Poole, LPC. I understand that Elizabeth Poole, LPC. will assist me in filing insurance claims, if appropriate, but that I remain responsible for charges. The standard fee for a 50 minute session is \$95.00. I expect charges will be made each time services are rendered and I agree to pay for all charges as follows:

I will pay the contracted fee at each visit (initial) _____
I will pay the co-payment as required by my insurance company (initial) _____
Amount of Co-payment \$ _____

Name of Insurance Company _____
Insurance Policy # _____ Group # _____
Phone # to verify benefits _____
Client Signature _____
Insured Signature _____
Date of Birth _____ Social Security _____
Home Address _____

Cell Phone # _____ Home # _____ Work # _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Elizabeth Poole, LPC. I understand that I am financially responsible for any of the balance. I also authorize release to my insurance company any information required to process my claims.

Signature: _____ Date _____