Nancy B. Sherrod, Ph.D., PLLC

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FINANCIAL INFORMATION FORM AND CANCELLATION POLICIES

Agreement to Pay for Professional Services

I request that Nancy B. Sherrod, Ph.D., PLLC provide professional services to me (or to _____, who is my _____,) and I agree to pay a fee of $ 160 per 60 minute session.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account.

I understand that fees will be collected at the end of each session. If fees are unpaid for over three months, a collection agency will be used. In the event that my account is turned over for collections or to an attorney, I will be responsible for all costs of collection or attorneys' fees. I understand that a therapist is not obligated to continue working with me if I have an unpaid balance or am no longer financially able to continue making payments.

I also understand that I (or this client) may choose to receive telephone consultation and that I will be charged the regular session rate for any telephone call that exceeds 15 minutes.

_____ _____

Signature of client Date

_____

Printed name

I, the therapist, have discussed the above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Therapist Date

Cancellation and Missed Sessions Policy

I understand that if I must cancel a session, I am expected to give a 24-hour notice other than for emergencies, illness or severe weather conditions. I understand that if I do not give the requested 24-hour notice, Dr. Sherrod may charge up to the full amount for missed sessions. If I am using insurance or Medicare, I understand that INSURANCE WILL NOT PAY FOR A MISSED SESSION and I may be charged more than my usual copay.

I understand that while Dr. Sherrod can provide a text or email reminder of my appointment, I am responsible for remembering my appointments and canceling within, REGARDLESS OF WHEN THE AUTOMATIC

REMINDER IS RECEIVED.

I understand that I may contact Nancy Sherrod by phone or text at 303-898-7583 or email at nancy@innerhealingpower.com to cancel an appointment.

I understand that frequent cancellations, last minute cancellations or no-shows may result in my being dropped from psychotherapy services. If I have problems (e.g., transportation difficulties, childcare difficulties) that affect my ability to attend my appointments, I will discuss this with my therapist ahead of time.

_____ _____
Signature of client Date

_____
Printed name

I, the therapist, have discussed the above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Therapist Date

Please Check One

___ I prefer to pay by cash or check at the end of each session.

___ I prefer to have statements sent to my address:

___ I prefer to pay by credit, debit or HSA/MSA card

___ Please bill my insurance. I understand I will be responsible for copays and/or coinsurance payments.

<u>Primary Insurance</u>

Your name: _____ Birthdate: _____Soc. Sec. #: _____

Male _ Female _ Marital Status: _____
Insurance Provider: _____ Identification/policy #:
_____
Name of subscriber (if different from patient):
_____
Subscriber's Soc. Sec. #:_____ Subscriber's Birthdate: _____ Group #: _____

<u>Secondary Insurance (if applicable)</u>

Insurance Provider: _____ Identification/policy #: _____
Name of subscriber (if different from patient):
_____
Subscriber's Soc. Sec. #:_____ Subscriber's Birthdate: _____ Group #: _____

I give this office permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

I understand that I am responsible for all charges, regardless of insurance coverage.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. By signing this agreement, you agree that I can provide requested information to your carrier.

Assignment of benefits I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

_____ _____

Client's (or parent/guardian's) signature, indicating agreement to all of the statements above

Date

_____

Printed name