Understanding of Financial Responsibility
Authorization to Bill Insurance

LIFE STRATEGY CONSULTANTS, LLC
Professional Counseling, Consulting & Educational Services

Statement of Financial Responsibility

Life Strategy Consultants, LLC is in-network and accepts payment from a variety of insurance providers and employee assistance programs. If Life Strategy Consultants, LLC does not accept your insurance, you may be able to use out-of-network benefits with your insurance provider. All clients have the option to select the "Self-Pay Rate" and pay for services without involving their insurance provider. Life Strategy Consultants, LLC does not bill secondary insurance payers.

Payment for each counseling session is expected at the time of service.

- For in-network insurance payments, the co-pay, co-insurance or deductible amount is due at the time of service.
- For out-of-network insurance and "Self-Pay," payment-in-full is due at the time of service.
- Failure to pay two consecutive appointments at the time of service may result in a pause in treatment until payment is received.
- Life Strategy Consultants, LLC accepts payment with
    - Credit/debit cards
    - Health Savings Account cards (HSA)
    - Flexible Spending Account cards (FSA)
    - Checks ***($35 charge for returned checks and NSF)***
    - Cash ***(Clinicians cannot provide change – overpayment is applied as credit on the account)***

I understand that all co-pays, co-insurance, deductible amounts, and "self-pay" rates are due at the time of service.
I understand that I am financially responsible for all charges whether or not they are paid by my insurance.
I understand that I am responsible for paying a "no-show" or "late-cancellation" fee of $50.00 when an appointment is missed without a 24 hour notice.
I understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts.

Client Signature_____ Date _____

Signature of Witness_____ Date _____

Revised January 2020

39 W Main Ave, PO Box 512, Myerstown, PA 17067
Secure Fax: (844) 252-3899

Recurring Credit Card Payment Authorization

As a benefit to our clients, Life Strategy Consultants will store your credit card payment information in an encrypted format in your electronic health record. By completing the information below,

- You authorize regularly scheduled charges to be applied to your credit card.
- You agree that no prior notification will be provided.
- You recognize that if the credit card is declined for any reason a bill will be mailed to the address provided.

I, _____, authorize Life Strategy Consultants to charge my Credit Card indicated below for fees from services rendered including **(Please place your initials next to each item)**:

_____Co-Pays

_____Co-Insurance

_____Deductibles

_____Late Cancellation Fees

_____Testing/Assessment Fees

_____Books & Material resources

_____Letter & Document completion

Billing Information

Billing Address _____

City _____ State _____ Zip _____

Phone # (_____)_____ Email Address _____

Card Details ☐ Visa ☐ MasterCard ☐ Discover ☐ AmEx

Cardholder Name (Printed) _____

Card Number ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ___ ____

Expiration Date _____ /_____ (MM/YY)

CVV/Security Code _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Life Strategy Consultants in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions so long as the transactions correspond to the terms indicated in this authorization form.

Cardholder's Signature _____ Date _____

Revised January 2020

39 W Main Ave, PO Box 512, Myerstown, PA 17067
Secure Fax: (844) 252-3899

Authorization to Bill Insurance

Is a preauthorization or referral required prior to receiving services? ❑ No ❑ Yes

Authorization/Referral # _____

Client Name_____ Date of Birth_____/_____/_____

Client's Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Life Partner ❑ Other Relationship

Insurance Company & Plan Name _____

Address _____

City_____ State_____ Zip _____

Phone Number (_____)_____ Fax Number (_____) _____

ID Number_____ Group Number _____

Policy Holder's Name_____ Policy Holder's Gender ❑ Male ❑ Female

Policy Holder's DOB_____/_____/_____

I consent to release the following information for the purpose of billing

☒ Admission
☒ Dates of Service/Attendance
☒ Diagnosis/Prognosis
☒ Summary of Treatment
☒ Patient Data Form
☒ Evaluations/Assessments
☒ Intake Note
☒ Progress Notes
☒ Termination Note
☒ Treatment Plan(s)

I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Life Strategy Consultants, LLC to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS, and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

Client Signature_____ Date _____

Signature of Witness_____ Date _____

This information is being disclosed from health records that may be protected by law. I understand that I have the right to request to inspect materials that will be released. I understand that I may revoke this authorization at any time by notifying Life Strategy Consultants, LLC staff verbally or in writing.

Revised January 2020

39 W Main Ave, PO Box 512, Myerstown, PA 17067
Secure Fax: (844) 252-3899