D. BRENT DAWSON COUNSELING AND MENTAL HEALTH

700 Central Expressway S. Suite 400 ~ Allen, TX 75013 ~ 214-687-8070

Client Financial Contract

Sessions and Fees:

This contract outlines D. Brent Dawson Counseling and his associates financial and business policies. Payment is expected at the time of each session in the form of cash, check, or credit card. D. Brent Dawson's professional services are covered by Blue Cross/Blue Shield. Any designated co-payments and/or deductibles are your financial responsibility. All sessions are 45-50 minutes in length. The fee for sessions with a **Licensed Professional Counselor** is $135. The session fee for sessions with a **Licensed Professional Counselor-Intern** is $35-$75. Our Interns often conduct sessions for a rate that is commiserate with most insurance plan's copay rate.

Returned Checks/Credit Card:

Returned checks that are written or declined card transactions, submitted to D. Brent Dawson Counseling and Mental Health or any of his associates, will result in a $40 NSF charge. **We request a credit or debit card be placed on file for clients receiving services.**

Blue Cross/Blue Shield:

D. Brent Dawson Counseling and Mental Health will file claims on your behalf to the primary, in-network insurance carrier you provide. You understand that you are ultimately responsible for any counseling fees not covered by your insurance carrier. Co-pays and any non-covered services are payable at the time of service. You will be billed for non-covered sessions. Court fees will not be filed with your insurance company and are your responsibility.

Assignment of Insurance Benefits:

In consideration of services provided by D. Brent Dawson Counseling and Mental Health or his associates, I hereby assign and transfer to D. Brent Dawson Counseling and Mental Health and any of his associates any and all rights, which I have against insurance companies, governmental agencies, or third party payers, for payment of charges for services provided by D. Brent Dawson Counseling and Mental Health or any of his associates to me or to one of my dependents. I authorize payment of all insurance benefits to be made directly to D. Brent Dawson or any of his associates for services provided to me.

I UNDERSTAND THAT CERTAIN INFORMATION MAY BE REQUIRED BY THIRD PARTY SOURCES FOR THE PURPOSE OF TREATMENT PAYMENT (INCLUDING COLLECTIONS OF PAST DUE ACCOUNTS) AND HEALTH CARE OPERATIONS. I HEREBY CONSENT TO D.BRENT DAWSON COUNELING AND MENTAL HEALTH RELEASING MY HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS. I HEREBY ASSIGN TO THE PRACTICE ALL BENEFITS/PAYMENTS NOT COVERED

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BY MYSELF AND/OR MY DEPENDENTS. I UNDERSTANDTHAT I AM RESPONSIBLE FOR ALL AMOUNTS NOT COVERED BY MY INSURANCE.

Financial Contract

MY SIGNATURE BELOW ALSO ACKNOWLEDGES THAT I HAVE READ AND AGREE TO THE CLIENT FINANCIAL CONTRACT.

Signature Of Client	Date:
Signature Of Guardian	Date: