

ANCHOR OF HOPE COUNSELING
PO Box 187, Clemson, S.C. 29633 (864) 654-7858

FINANCIAL AGREEMENT

Client/Patient: _____

I understand that I am obligated to pay the client/patient's account according to the regular rates and terms of Anchor of Hope Counseling and its Associates. I do hereby appoint as my true and lawful attorney Anchor of Hope Counseling and/or its Associates to collect the claims, endorsed checks, and give full and final receipt for all amounts collected. In the event benefits exceed the actual charges for this account, I authorize Anchor of Hope Counseling or its Associates to apply the overpayment to any other account for which I am responsible. I understand that Anchor of Hope Counseling could obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or an attorney for collection, the undersigned shall pay all collection fees and reasonable attorney's fees.

Reminder: Your insurance policy is a legal contract between you and your insurance company and reimbursable to you, not this office, unless there is an agreement for your insurance company to pay this office directly. A billing statement will be provided you so that you may send it to your insurance company for reimbursement. This office will cooperate fully with any insurance company in order that you may be reimbursed.

Since we are treating you and not your insurance company, your counseling sessions-bill is your responsibility. The fee for treatment is an obligation that you have with this office/counselor and is due at the time of service.

Missed appointments are charged at full fee and cannot be charged to your insurance company. So please give a 24-hour notice to avoid the fee for a missed appointment. Your credit card or blank check will be placed on file. Any outstanding balances at the end of the month will be billed.

There will be a charge for any miscellaneous forms or letters that are generated above and beyond the usual services.

Thank you.
Anchor of Hope Counseling

Acknowledgement: I have read the Authorization for Treatment and the Financial Agreement, have had the opportunity to ask questions about the information they contain, and agree to abide by it.

Signature / Date

Signature / Date