WWW. SHONDAMORALIS.NET
SHONDA@SHONDAMORALIS.NET

## FINANCIAL AGREEMENT AND INSURANCE POLICY

Benefits will be verified upon receipt of your insurance information and you will be made aware of any estimated out-of-pocket expenses. Information obtained from insurance companies is not always a guarantee of payment. Families are ultimately responsible for payment for non-covered services. It is imperative that families are aware of their insurance coverage and their potential responsibilities. We will strive to keep open communication regarding insurance/payment and clients will inform Shonda Moralis, MSW, LCSW of any changes regarding insurance. Client will assign benefits for filed claims to be paid to Shonda Moralis, MSW, LCSW and any payment(s) sent directly to the family intended to cover therapy provided by Shonda Moralis, MSW, LCSW should be immediately forwarded to Shonda Moralis, MSW, LCSW's office.

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**Client/Guardian/POA initials**

The usual and customary rate for services is billed to insurance. If we bill your insurance and you have a deductible, the full amount to your deductible will be billed to you. Shonda Moralis, MSW, LCSW reminds clients that they are responsible for all co-pays, coinsurance, and deductible expenses associated with each date of service. Shonda Moralis, MSW, LCSW accepts cash, check, or credit. There is a $30 fee for all checks returned from the bank for any reason. I request that payment of authorized medical benefits is made on my behalf directly to Shonda Moralis, MSW, LCSW, the provider of service.

**Cancellation Policy:** Please note that if you need to cancel or reschedule your appointment I require notice at least twenty-four hours prior to our scheduled appointment time. The fee for a session cancelled without twenty-four hours notice is $50 and is the responsibility of the client.

I authorize Shonda Moralis, MSW, LCSW to release any medical information to my health insurance and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance to HIPPA health information standards. I authorize payment of service (s), otherwise payable to me under the terms of my employer's group health insurance plan, directly to Shonda Moralis, MSW, LCSW. I hereby authorize that photocopies of this form valid as the original.

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**Client/Guardian**

## CONSENT TO TREAT

I, _____consent for Shonda Moralis, MSW, LCSW to provide psychotherapy services. I consent to care and treatment falling under the practice guidelines and the State of Pennsylvania, I acknowledge the treatment that Shonda Moralis, MSW, LCSW is providing me and recommending is in my best interest and agree with it.

_____ _____
**Client/Guardian Signature** **DATE**

_____ **PRINTED NAME**