Keystone
Counseling & Consulting LLC

156 Milestone Way, Suite B, Greenville, South Carolina 29615
Phone 864·297·5377 Fax 864·297·6387

FINANCIAL POLICIES

Initial each statement below and have all responsisible parties sign form to acknowledge and agree to policies.

Patient(s) Name: _____

_____ Each patient is financially responsible for payment of therapy services provided. PAYMENT IS DUE AT THE CONCLUSION OF EACH SESSION IN FULL. Payment is accepted in cash or check made out to Keystone Counseling.

_____ Keystone Counseling & Consulting, LLC agrees to file insurance claims as a courtesy to our clients and receive insurance payments on their behalf. Should an insurance company decline or not pay for service, partially or in full, for ANY reason, it is the client's responsibility to pay for these services in full.

_____ It is each client's responsibility to keep track of all insurance authorizations. Obtaining insurance authorizations and providing them to the Therapist are the sole responsibilty of the patient.

_____ Any insurance balance that has gone unpaid for 30 days becomes the responsibility of the patient and will be paid immediatley upon request.

_____ Keystone Counseling & Consulting, LLC requires 24 **business hours** to cancel or reschedule your appointment. IF YOU CANCEL A SESSION WITH LESS THAN 24 HOURS NOTICE YOU WILL BE CHARGED FOR THE SESSION. You must cancel a Monday appointment by 2:00 pm Friday. Please make cancellations directly with your therapist by phone. Cancellations will not be accepted by e-mail.

_____ Insurance Companies do not cover late cancellations or no show charges. Please be prepared to pay "no-show" fees by cash or check in full prior to your next session.

_____ All fees for services are posted in the reception area. You may also request a copy of these fees from your therapist at any time.

_____ There is a $25.00 fee for all returned checks. Once there has been a returned check your therapist may require payment in cash or money order for future sessions.

If more than one individual (e.g., couple, family, multiple parties) is seeking therapy, each individual's signature is required. Signatures indicate they have read this form and consent to Keystone's Financial Policies.

_____	_____	_____
Responsible Party 1 (Client or Guardian)	Signature	Date
_____	_____	_____
Responsible Party 2	Signature	Date