**PATHWAYS: Counseling and Consulting Services, Inc.**
**Maria Adigweme, LMHC, CAP**

## FINANCIAL AGREEMENT

My insurance policy is a contract between my insurance company and me.
I understand that Maria Adigweme, LMHC,CAP will submit bills to my insurance company.

I am responsible for any co-payments, deductibles, or amounts, which my insurance company does not pay to Maria Adigweme, LMHC,CAP.

I understand that if payment will not be used by my insurance to Maria Adigweme, LMHC,CAP, I am responsible for payment in full, at the time of service.

Regarding children's appointments; the **parent or guardian <u>bringing</u>** the child to the appointment will be responsible for any co-payments or deductible due at the time of service.

****I understand that I will be financially responsible for any missed appointments, without a <u>24 hour</u> notice****

**Signature_____Date_____**

**The following authorization allows "Signature on file" to be printed on claim forms:**

## INFORMATION RELEASE

I authorize the release of any medical or other information to my insurance company/EAP necessary to process this claim.

**Patient/Guardian's Signature_____Date_____**

## ASSIGNMENT OF BENEFITS

I authorize payment for medical benefits to Maria Adigweme, LMHC,CAP for billed dates of service.

**Patient/Guardian's Signature_____Date_____**