SAMARITAN COUNSELING SERVICES OF THE GULF COAST

FINANCIAL AGREEMENT FORM

Client Name: _____

Client Name: _____

DSM V/ICD10 Code (if necessary): _____

Is Client Using Insurance: ☐ Yes ☐ No

Insurance Company Name: _____

Client Co-Pay: _____

Is Client Using Church/Other: ☐ Yes ☐ No

Church/Other Name: _____

Church/Other Payment: _____

Client Responsibility: _____

Is Client Using CAF: ☐ Yes ☐ No

Client Assistance Fund (CAF): _____

McCune Fund: _____

Bladel Fund: _____

Client Responsibility: _____

Is Client Private Pay: ☐ Yes ☐ No _____

ALL SOURCES MUST TOTAL 115/105

I authorize the release of information necessary to process insurance claims filed on my behalf. I assign payment of insurance benefits to Samaritan. I know that I am financially and legally responsible for payment of services rendered whether or not my health insurance covers the services rendered.

Client's Signature: _____ Date: _____

Client's Signature: _____ Date: _____

Counselor's Signature: _____ Date: _____