

SAMARITAN COUNSELING SERVICES OF THE GULF COAST
FINANCIAL AGREEMENT FORM

Client Name: _____ Client ID#: _____

Is Client Using Insurance: Yes No

Insurance Company: _____

Client Co-Pay: _____

Insurance Adjustment: _____

DSM V/ICD10 Code: _____

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): _____

Silent Samaritan: _____

Keith G. Hirst: _____

ALL SOURCES MUST TOTAL 115/100

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: _____

Counselor's Signature: _____ Date: _____