Mark Kaplafka Counseling, LLC
20545 Center Ridge Road, Suite 125
Rocky River, OH 44116

Financial Agreement

I understand that regular attendance will produce the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so, I will notify Mark Kaplafka Counseling, LLC at least two weeks in advance so that effective planning for continued care can be implemented. I also agree to notify Mark Kaplafka Counseling, LLC at least 24 hours in advance if I will be unable to attend a scheduled session. I understand that if I fail to make such notification, I will be charged for the full cost of the session which will not be reimbursable by my insurance company. I understand I will be charged for this missed appointment on the day of the scheduled appointment. I agree to be responsible for these charges and understand that my credit card or other payment method, that is stored on file, will be charged for these fees. If my payment method on file does not accept these or any charges incurred, I understand that I will be charged a $50 penalty and will be required to pay off this fee prior to your next scheduled session. I understand that all balances must be paid prior to my next appointment with Mark Kaplafka Counseling, LLC.

If patients are interested in seeking out of network reimbursement through their insurance, you acknowledge that you are responsible for providing accurate information about your insurance information. Failure to complete this section or inaccurate information will make patients fully responsible for all charges. Patients are responsible for notifying Mark Kaplafka Counseling, LLC of any changes in insurance within 30 days; otherwise, I understand that I will be responsible for payment in full. Patients are responsible for making the initial phone call to their insurance companies to determine benefits eligibility and to understand their financial responsibility for their services with Mark Kaplafka Counseling, LLC as this practice does not bill insurance directly for services.

I understand that I have the right to choose to pay for my services out of pocket or to use my out of network health insurance benefits to reimburse me directly. If I elect to use these out of network benefits, I understand that it is my responsibility to submit the required information to my insurance company. I grant permission to Mark Kaplafka Counseling, LLC to release such confidential information as is necessary for me to obtain payment from the insurance company.

I understand that I am financially responsible for the cost of the mental health services provided to me. I understand that failure to pay these bills may result in collection procedures (including court proceedings) being taken against me by Mark Kaplafka Counseling, LLC or a collection agency contracted by Mark Kaplafka Counseling, LLC to collect these bills. I also understand that if my account is placed in collections procedures, neither I nor any other patient of Mark Kaplafka Counseling, LLC for whom I am the guarantor will be able to schedule appointments.

I authorize the release of any medical information necessary to process my request to seek reimbursement through my out of network benefits.

I hereby authorize Mark Kaplafka Counseling, LLC to charge my debit or credit card or other payment method to satisfy future payment obligations. I acknowledge that the initiation of all such entries to make payments on my account with Mark Kaplafka Counseling, LLC must comply with provisions of U.S. law and any applicable state laws. I understand and agree that these entries may be made to my debit card, credit card or other payment methods periodically to pay amounts owed by me to Mark Kaplafka Counseling, LLC. I also agree to notify Mark Kaplafka Counseling, LLC if my payment method information

changes for any reason. This authorization shall remain in effect until I communicate with Mark Kaplafka Counseling, LLC in writing, my intention to cancel this authorization. In the event of a returned electronic or declined charge, my account will be charged $50 service fee for each occurrence.

By signing the document below, you are acknowledging that you have read the materials in this Consent form and agree to abide by its terms and conditions.

In the event that the client is a child, the parent(s) are signing this on behalf of the child(ren).