kp counseling
Client Financial Agreement

Client Name _____

Responsible Party Name_____
(Please print responsible party name if different than client)

I understand that I am responsible for paying any Deductible, Coinsurance or Co-pays due at the time of service.

I understand that I have the choice to pay myself at the time of service or can opt to have a credit card on file that will be charged for any amount due**. (Please check the box of your choice)**

☐ **I will pay myself at the time of service**

(I understand that if I choose to pay at the time of service and fail to pay 3 payments any future appointments will be cancelled until my account is made current.)

Signature: _____ Date: _____

or

☐ **I authorize kp counseling to take an imprint or copy of my credit card to have on file to be charged at the time of service for any deductible/coinsurance or co-pay amounts due. I understand that if my insurance carrier also reimburses kp counseling I will be reimbursed for any over payment.**

Name on card _____

Address _____

Credit card number _____Phone#_____

Expiration date ____/____ 3 digit security code_____ Zip Code _____

Signature: _____ Date: _____

kp representative: _____ Date: _____

This agreement is good for one year from the date signed. You may choose to opt out of auto payment at any time by contacting our Business Office 779-368-0060.