



NEW CLIENT FINANCIAL INFORMATION, FINANCIAL AGREEMENT AND INSURANCE COMPANY RELEASE

Our fees are fair and competitive. Fees will vary with the type of services provided. The Initial Evaluation is \$165.00, Psychotherapy (Individual, Couples or Family), 45-50 minutes is \$110.00. Full payment is due at the time of service; unless you have insurance coverage and we are a participating member to your insurance plan. Cash, credit card, or check is accepted. Please make checks payable to Compass or Compass Professional Services LLC.

Insurance coverage is a contract between you and your insurance company. In some cases, we may be a party to this contract. Please ask if we are a participating member to your insurance plan. We will handle your claim according to our agreement with your insurance company. Our office has provided you a list of important questions for your insurance company. You must know your limitations for your plan's coverage. You must notify us of any changes in your coverage within 15 days of the change. We will not become involved in disputes between you and your insurance company (i.e., deductibles, co-payments, coverage changes, secondary insurance) other than to supply factual information as necessary. You are responsible for all fees unpaid by your insurance company.

To make sure we are operating on the same agreement regarding sessions, we have defined the following guidelines. Once you have agreed upon an appointment time, you are responsible for that time. If you foresee that you cannot keep the appointment time, you will need to give us at least a 24 hour cancellation notice or you will be charged for the time. Medical emergencies are acceptable for short notice.

Feel free to ask about our fees at anytime. Timely payment is expected. With your signature, you give us permission to provide the necessary information for any and all billing. Billing questions should be directed to our Office Manager Kelly Dziak at (406) 782-4778 or 565-0168. In the event that your balance goes unpaid, we will turn your account over to a collection agency. Any fees incurred by us to collect on your bill will be your added responsibility. Our service charge for returned items is \$55.

CLIENT INFORMATION

Client Name (First) (MI) (Last) Marital Status
Address City State Zip
Phone No. (Home) (Work) (Cell)
Social Security Number Sex: F M Age Date of Birth

PRIMARY INSURANCE

Name of Insurance Phone No.
Address City State Zip
Insured's Name Date of Birth
Relationship: Self Spouse Parent/Legal Guardian Other
Insured Through: Self Employer Employer Name Phone No.
ID Number Group Number

SECONDARY INSURANCE

Name of Insurance Phone No.
Address City State Zip
Insured's Name Date of Birth
Relationship: Self Spouse Parent/Legal Guardian Other
Insured Through: Self Employer Employer Name Phone No.
ID Number Group Number

RESPONSIBLE PARTY FOR PAYMENT if different from client or parent/guardian of a minor child

Name (First) (MI) (Last) Marital Status
Address City State Zip
Phone No. (Home) (Work) (Cell)
Social Security Number Sex: F M Age Date of Birth
Relationship: Spouse Parent/Legal Guardian Other

INSURANCE COMPANY RELEASE OF INFORMATION

I/We hereby authorize Compass Professional Services LLC to disclose to my insurance company, listed above, only the following information: patient name, date(s) of service, service(s) provided, and diagnosis, to be used for the purpose of insurance evaluation and reimbursement.

This information will be disclosed to the above insurance company from records whose confidentiality is protected by Montana and/or federal law. These regulations prohibit the above insurance company from making any further disclosure of this information without prior written consent. I understand that I have no obligation whatsoever to disclose any information from my record. I understand that I may revoke this consent at any time by notifying Compass Professional Services LLC or the above-noted person, organization, or agency, in writing and/or by specifying an event or condition upon which my consent will expire without revocation. I have read or had this form read and explained to me and I understand its contents.

I have completed the above to the best of my ability and fully understand the importance of this relationship. I have reviewed the terms in the financial agreement and agree to abide by the terms as outlined for services provided by Compass Professional Services LLC. I give my consent and with my signature to provide the necessary information for any and all billing of the services rendered. This authorization will automatically expire in 12 months from the date signed.

Client Signature Date
Client Signature Date
Parent/Legal Guardian Signature mandatory if client is a minor Date
Therapist/Representative of Compass Professional Services LLC Date