Big Sky Family Therapy

Stephanie Isbell, MA, LCPC

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Family Systems Trauma Therapy
Advanced Certificate

DIR/Floortime
Advanced Certificate

Agreement to Pay for Professional Services
Assignment of Benefits and Release of Information

I request that the therapist named below provide professional services to me.

Print name: _____

Agreement to pay: I agree to pay for all counseling charges incurred. Services include therapy sessions and notes with suggestions and phone consultations with other professionals.

Please place check mark in each box to indicate understanding and agreement with each condition.

☐ I authorize payment of medical benefits billed to my insurance to Big Sky Family Therapy (BSFT). I accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I authorize BSFT to disclose my health information for treatment, account balance resolutions, and other healthcare operations to appropriate agencies.

☐ I understand I will be charged $50 for all missed appointments unless the appointment is canceled 24 hours prior to the scheduled time.

☐ I understand that letters, summary reports and court involvement are not covered by this agreement.

☐ I agree to pay a negotiated flat fee for a letter or report or a negotiated hourly fee for court involvement.

☐ Release of Information: I grant Stephanie Isbell, MA, LCPC, authorization to release any information necessary for the completion of all claims relating to counseling services provided. This information may be released to my insurance company or others providing third party reimbursement for these services.

PRINT NAME: _____ **DATE:** _____

SIGNATURE: _____