Susan Ruby, MA, LMHC
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INSURANCE AGREEMENT

Client Name: _____ Birthday (M/D/YY): _____

Name of Insured Person: _____ Birthday (M/D/YY): _____

Address of Insured Person: _____

Insured Person's Phone Number: _____

Client Relationship to Insured: ☐ Self ☐ Child ☐ Spouse/Partner ☐ Other: _____

Insurance Company: _____ Plan Name: _____

ID Number on Card: _____ Group Number: _____

Insured Person's Employer: _____

Deductible: _____ Has the deductible been met this year? ☐ Yes ☐ No

Number of Sessions Allowed per Year: _____

Fee Without Insurance: $120

Co-Pay Due at Each Session: _____

Late Cancellation / No Show Fee: $90

CONSUMER RESPONSIBILITY STATEMENT

- I understand that my portion of the fee (co-pay/co-insurance) is due at time of service.
- I understand that a no show fee will be charged for appointments cancelled without 24 hours notice. Because insurance does not pay for missed sessions, I will be responsible for the full fee, not just the co-pay.
- I understand that I am responsible for paying my deductible and any amounts not covered by insurance. If I have secondary insurance, I understand that I will be responsible for submitting claims against that insurance, and that I will be responsible for any amount not covered by my primary insurance.
- I understand that if, for any reason, my insurance company does not pay my fee, I am responsible for the entire amount.
- I authorize the release of information needed to verify and process insurance claims to Susan Ruby, MA, LMHC.

_____ _____

Client or Parent Signature *Date*