Bebe Brezanin-Brusky, MSW, LCSW
Licensed Clinical Social Worker
Adolescent, Adult & Couples Counseling
bebebruskylcsw@gmail.com
908-208-2119

Financial Agreement - In Network

Client Name:_______________________________ Birth date:___________________________

Address:____

Name of Person Responsible for Payment: ____

Address and phone number (if different): ____

____

Health Plan Name: ____

ID#: ____

Group #:____

Primary/Insurance Subscriber Name (if different):__________________________ Date of birth:_______

Address (if different)____

Annual Deductible Met __________ Yes _________No

If deductible is not met I agree to pay fee of $__________per session

Co-pay/co-insurance fee of $___________per session

For office use	
Diagnosis:	
Onset:	
Prior diagnosis:	
Onset:	

Note:

- Provider will file in-network claims
- Payment by check made out to “Touchstone Counseling Services, LLC or cash is due at the start of each therapy session
- **cancellation is required at least 24 hours in advance or you will be charged a $120.00 for late cancellation or missed session (insurance is not billed for your missed sessions)**
- **A $25 fee will be charged for retuned checks**
- **You are responsible for payment in the event that insurance claim is denied**

I have read, understood and agree to the above outlined financial agreement.

Client Name: _______________________Client Signature:____________________ Date:_________

Client Name: _______________________Client Signature:____________________ Date:_________

Parent/Guardian: ___________ Parent/Guardian Signature: ____________________Date:_________

Parent/Guardian: ___________ Parent/Guardian Signature: ____________________Date:_________

My signature below indicates that I have discussed this form with you and have answered all questions you have regarding this information

____ ___________________

Therapist’s Signature Date

Revised 11/18/18