Davis Dynamics A Jana Davis, LCSW 317 Office Square Lane, Suite 202B Virginia Beach, VA 23462

Financial Agreement

Full Name:_____

Birth Date:_____ **Social Security #:**____-___-_____

( ) **I have agreed to pay privately for my therapy.** The agreed upon charge is $____ per session. Paperwork or other requests will be a separate charge if not completed during the allotted time. I acknowledge that my insurance will not reimburse me for my decision to see Jana Davis, LCSW privately. Davis Dynamics is not to bill my insurance.

Signature: _____ Date: _____

( ) **I have agreed to pay using my insurance**

Clients who wish to use their insurance should know that professional services are rendered and charged to the client and not to the insurance companies. Your insurance is a personal contract between you and your insurance company. If you would like for us (Tammy Warren, biller, and/or Jana Davis, LCSW) to file your claim for you, please provide your insurance card at the beginning of the first session. Without your card or proof of insurance, your claim cannot be filed. Payment is due in full on the date of service, unless other arrangements have been made or we have a contract stating otherwise with your insurance company. It is your responsibility to pay any deductible amount, co-pay, co-insurance amount, or any other balance not paid by your insurance the day and time service is provided. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services, however, you remain responsible for charges to any service rendered.

1. **I authorize use of this form on all of my insurance submissions.**
2. **I authorize the release of information to my insurance company(s).**
3. **I understand I am responsible for the full amount of my bill for services provided.**
4. **I authorize direct payment to my service provider.**
5. **I hereby permit a copy of this to be used in place of an original.**

Signature: _____ Date: _____

There will be a $35 service charge on all returned checks. In the event your account goes into collections, there will be a 20% collection fee added to your balance.

There is a 24 hour cancellation policy which requires you to cancel your appointment 24 hours in advance to avoid charges. **If I do not receive 24 hour advance notice, you will be responsible to pay a fee of $50.00**

Printed Name: _____

Signature: _____ Date: _____