

Authorization for Compensation/Responsibility for Payment

You are responsible for payment for all services. If your insurance will cover my services I will be happy to assist you in obtaining appropriate payment. If I am a panel member of your health care provider I accept the reduced payment imposed by managed care programs and cannot bill you for the difference between their payment and my usual and customary fee. If I am not a provider I will accept out of network benefits, if applicable; you will be responsible for the difference. If your insurance company has no out of network benefits then you are responsible for the bill in its entirety. I may require your assistance in obtaining appropriate compensation from your insurance plan.

Thank you.

Phil E. Foster, MDiv, LPC, NCC, DAPA

I hereby acknowledge responsibility for the payment of my account.

Signature _____ Date _____

I authorize you to seek reimbursement from my health care insurer.

Signature _____ Date _____

I authorize you to release such information to my healthcare provider that is necessary for reimbursement.

Signature _____ Date _____