

Client Financial Responsibilities

The Office of
Aracely Neeley, LCSW
Important Please READ and Initial

1. _____ I understand that I am responsible for any amount that my insurance does not cover; including when I have not yet met my deductible.
2. _____ If my insurance is not in effect/has been canceled and or mental health benefits are not covered I am fully responsible for any and all balances due to Aracely Neeley, LCSW and must be paid within 14 days from the date of service.
3. _____ I will be responsible for any returned check fees and will pay all fees before any further appointments are made; (includes but not limited to: filing a Stop Payment, Insufficient Funds, Closed Account etc.). **Penalty for returned checks: \$30.**
4. _____ If I do not have proof of insurance OR proof of insurance is pending I understand I must pay the full consultation fee prior to the session.
5. _____ I understand the office policy that a **MINIMUM** of a 24 hour notice is required to avoid the **\$98 cancellation fee**. I understand that leaving a voicemail is acceptable as long as it is with a 24 hour's notice.
6. _____ I understand that payment is due prior to the appointment.
7. _____ I understand that if I come to my initial session without confirming with my insurance about my co-pay, I will be required to pay a minimum of \$50 to Aracely Neeley, LCSW and if applicable any credit will be forwarded to the next appointment fee.

I HAVE READ ALL OF THE ABOVE AND MY INITIALS INDICATE MY UNDERSTANDING AND ACCEPTANCE OF SUCH REQUIREMENTS TO ATTEND PSYCHOTHERAPY SESSIONS WITH ARACELY NEELEY, LCSW.

CLIENT SIGNATURE

DATE