The Journey Therapy LLC

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PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing The Journey Therapy LLC as your provider for mental health services. We are committed to providing you with the highest quality care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- **The patient (or patients guardian, if a minor) is ultimately responsible for the payment for treatment and care.**
- **We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.**
- **Patients are responsible for payment of copays, coinsurance, deductibles, taxes and all other treatment not covered by their insurance plan.**
- **Copays are due at the time of service**
- **Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:**

○ **Charge for returned checks** ○ **Charge for missing appointments without 24 hour notice ($100).**

By my signature below, I hereby authorize assignment of financial benefits directly to The Journey Therapy LLC and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form

_____ (Client name)

_____ (name of parent or guardian)

_____ (Signature of parent or guardian)

_____ (date)

_____ (date)