ARCH PSYCHOTHERAPY & WELLNESS
225 S. MERAMEC AVE, SUITE 218
CLAYTON, MO 63105
WWW.ARCHPSYCHOTHERAPY.COM

Insurance Billing Agreement

Name(s):_____

Billing Address:_____

City:_____ State:_____ Zip:_____

Phone(s):_____

E-mail(s):_____

Insurance Company:_____

Insurance Claims Phone #:_____

Policy #:_____ Group #:_____

Please initial each of the following to indicate agreement:

_____I give consent for my health information to be used for purposes of insurance reimbursement.

_____I agree to pay all required copays, coinsurance or deductibles, due at the time of service.

_____I understand that a convenience fee of 3% will be assessed for credit card transactions.

_____I agree to pay a late cancellation fee of $75 for sessions not attended and not cancelled with 24 hours' notice (insurance does not reimburse for missed sessions).

_____I understand that in the event my insurance company does not pay for services I have received according to the terms of its agreement that I am ultimately responsible for the remaining balance due to my provider.

_____ _____
Signature of client or payor Date

_____ _____
Signature of second client or payor (if applicable) Date

_____ _____
Representative of Arch Psychotherapy & Wellness Date