Morning Light Counseling Services
Client Insurance Agreement

Date:_____

I, _____understand that:

- The charge for each session at Morning Light Counseling Services is $125.00 unless otherwise noted on the Consent for Services form. An itemized receipt for services will be provided upon request.
- I am responsible for providing Morning Light Counseling Services with the information necessary to bill any insurance company including having my insurance card at each visit.
- Morning Light Counseling Services will submit a claim to my insurance company as a courtesy.
- I am responsible for any co-payment, deductible amount and/or any remaining balance of the agreed fee incurred on behalf of myself and/or my child with Morning Light Counseling Services, that is denied in whole or in part by my insurance company.
- I am responsible for any discrepancies in co-pay if the co-pay is determined to be more than what was initially collected. The amount of co-pay is determined by the insurance company and stated on the EOB (eligibility of benefits) for the date of the visit. This amount may vary from the amount the insurance company quoted and this is beyond the control of Morning Light Counseling Services. Morning Light Counseling Services will refund and/or credit my account the difference if the actual co-pay is less than what was collected.
- If I have more than one insurance provider, my primary insurance carrier must be billed prior to any other providers. I am responsible to provide all information necessary to process billing to my insurance carrier.
- I am responsible for notifying Denise Smith of any change in my insurance coverage before my next appointment.
- I will cooperate with Morning Light fully and promptly when information or action is requested of me.
- I authorize information to be shared with a third party (i.e. insurance company or bill collect, if necessary) for the purpose of processing changes on my or my child's account.

The following is my insurance information:
Name of Primary Insurance Company_____
Name of Policy Holder (Insured)_____ID#_____
Employer of Policy Holder_____Grp#_____
Policy Holder's Address_____
Date of Birth_____ Relationship to Client_____
Social Security #_____

Name of Secondary Insurance Company_____
Name of Policy Holder (Insured)_____ID#_____
Employer of Policy Holder_____Grp#_____
Policy Holder's Address_____
Date of Birth_____ Relationship to Client_____
Social Security # _____

I understand and agree that I am ultimately responsible for all charges incurred as a client of Morning Light Counseling Services. I have read and understand all of the information above. I certify that the information provided is true and correct to the best of my knowledge and will notify you immediately of any changes.

_____ _____ _____
Parent's Printed Name Client's Printed Name Client's Signature(Parent if Minor)