Annemarie Husser LCPC, LLC
455 Coventry Lane, Suite 105
Crystal Lake, IL 60014
779-704-0931

Financial Agreement

Payment

Initial_____You will be required to pay for each session at the time it is held, unless we agree otherwise or you have insurance coverage which requires another agreement**. You will always be expected to pay the insurance co-pay, co-insurance or deductible amounts at the time of service. If your deductible has not been met, a payment is expected at the time of service.** Payment may be in the form of check, cash, or credit card. My rate is $180.00 for a 60 minute session, $140.00 for a 45 minute session and $100.00 for a 30 minute session. Contacting Annemarie Husser LCPC by phone to discuss matters besides an appointment reschedule may result in a session charge that cannot be billed by insurance. Annemarie Husser LCPC only responds to email or text for rescheduling purposes. The returned check fee is $100.00**. Any work outside scheduled sessions is fee based**.

Appointments

Initial_____ If I am unable to keep an appointment, I will provide notification as soon as possible. If an appointment is canceled or missed without 24 hours' notice, **I understand that I will be billed at a late cancellation fee of $50.00 and a no show fee of $75.00**. **Mental health emergencies are not managed in this out-patient office. You are to call 911 or go to your nearest hospital emergency room for services.**

Insurance

Initial_____I understand that you may provide me with a receipt which I can use to file my insurance if Annemarie Husser LCPC is not a participating provider on my insurance plan. You may provide a service for me by filing insurance on my behalf if Annemarie Husser LCPC is a participating provider on my insurance plan. When you provide this service, I authorize you to release medical or other necessary information to process the claim and I authorize payment to Annemarie Husser LCPC. I understand that Annemarie Husser LCPC will be submitting a clinical diagnosis for the person identified as the client on the insurance claim form in order to receive reimbursement. **In the event that my insurance will not pay for any services provided, I understand that I am responsible for the full payment.**

Privacy Notice

Your signature affirms that you acknowledge that you have received the Notice of Privacy Practices from Annemarie Husser LCPC. I understand that Annemarie Husser LCPC does not testify in court cases. I have read, initialed and agree with the above statements:

Signature of client/guardian: _____

_____Date:_____

Signature of Witness: _____Date:_____