Eric B. Tedstrom, LCSW, LLC
Individual, Family and Group Therapy
**720-427-0731**

# FINANCIAL AGREEMENT

Payment Responsibility
I understand that I am responsible for payment of all fees charged. I agree to pay for all services rendered, unless my insurance carrier (if I have one) pays for some or all charges. If I have insurance, I agree to make the co-payment for services rendered at the time of each visit. I understand that insurance claims will be submitted on my behalf, including those with or without a co-payment arrangement. I understand that if my insurance company denies payment, does not reimburse EBT, LCSW, LLC within 60 days for services rendered, or reimburses EBT, LCSW, LLC differently than they initially indicated, I will be personally responsible for payment.

Non-covered Charges
Charges for services which are not benefits of the insurance plan are the patient's responsibility. These may include, but may not be limited to telephone calls or email to a patient or collateral source for consultation or counseling, preparation of reports for other professionals, agencies, insurance carriers or attorneys, activity fees for group field trips and missed appointment fees.

Deductibles
Please note that if you have a deductible to meet, you are responsible for the full amount of your sessions until your deductible is met.

Unpaid balance
Any balance not paid after thirty days may be assessed a service charge of $25 per month. After 3 months delinquent accounts may be sent to a collection agency.

Current regular session rate: $85 (may change at any time).

By signing this agreement I acknowledge an understanding of these policies.

Patient Printed Name: _____

_____ _____
Financially Responsible Party Financially Responsible Signature

Insurance Company: _____ Subscriber DOB: _____

Subscriber ID#: _____ Subscriber SS#: _____

_____ _____
Date Signature of Therapist