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CREDIT CARD AND FINANCIAL AGREEMENT

I understand that regular attendance will produce the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so, I will notify Inner Harmony Counseling, LLC at least two weeks in advance so that effective planning for continued care can be implemented. I also agree to notify Inner Harmony Counseling, LLC more than 24 hours in advance if I will be unable to attend a scheduled session. I understand that if I fail to make such notification, I will be charged for the full cost of the session which will not be reimbursable by my insurance company. I understand I will be charged for this missed appointment on the day of the scheduled appointment. I agree to be responsible for these charges and understand that my credit card, that is stored on file, will be charged for these fees. If my credit card on file does not accept these or any charges incurred, I understand that I will be charged a $50 penalty and will be required to pay off this fee prior to your next scheduled session. I understand that all balances must be paid prior to my next appointment with Inner Harmony Counseling, LLC

Patients are responsible for providing accurate information about their insurance benefits. Failure to complete this section or inaccurate information will make patients fully responsible for all charges. Patients are responsible for notifying Inner Harmony Counseling, LLC of any changes in insurance within 30 days; otherwise, I understand that I will be responsible for payment in full. Patients are responsible for making the initial phone call to their insurance companies to determine benefits eligibility and to understand their financial responsibility for their services with Inner Harmony Counseling, LLC.

I understand that I have the right to choose to pay for my services out of pocket or to use my health insurance to pay for these services. If I elect to use my benefits, I request that Inner Harmony Counseling, LLC, submit bills to the insurance company that I have listed as my insurance company, and I grant permission to Inner Harmony Counseling, LLC to release such confidential information as is necessary to obtain payment from the insurance company. In the event that my insurance company fails to observe Ohio prompt pay standards or otherwise fails to adhere to relevant rules and standards, I grant permission to Inner Harmony Counseling, LLC to share information related to my insurance claim with the Ohio Department of Insurance.

I understand that I am financially responsible for the cost of the mental health services provided to me and for any portion of the fees not reimbursed or covered by my health insurance. I understand that my copay is due at the time of service. If my mental health care is provided under the terms and conditions of a managed mental health care program to which Inner Harmony Counseling, LLC is contracted, my financial responsibilities may be limited by the terms of that contract. I understand that failure to pay these bills may result in collection procedures (including court proceedings) being taken against me by Inner Harmony Counseling, LLC or a collection agency contracted by Inner Harmony Counseling, LLC to collect these bills. I also understand that if my account is placed in collections procedures, neither I nor any other patient of Inner Harmony Counseling, LLC for whom I am the guarantor will be able to schedule appointments.

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I authorize the release of any medical information necessary to process my claim.

I hereby authorize Inner Harmony Counseling, LLC to charge my debit or credit card to satisfy future payment obligations. I acknowledge that the initiation of all such entries to make payments on my account with Inner Harmony Counseling, LLC must comply with provisions of U.S. law and any applicable state laws. I understand and agree that these entries may be made to my debit or credit card periodically to pay amounts owed by me to Inner Harmony Counseling, LLC. I also agree to notify Inner Harmony Counseling, LLC if my debit or credit card changes for any reason. This authorization shall remain in effect until I communicate with Inner Harmony Counseling, LLC in writing, my intention to cancel this authorization. In the event of a returned electronic or declined charge, my account will be charged $50 service fee for each occurrence.

My signature below indicates that I have agreed to the above terms.